State of Maryland

July 2006 – June 2007

GUIDE TO YOUR HEALTH BENEFITS

Did You Know?

- YOU WILL NOT PAY MORE THAN $700 IN PRESCRIPTION CO-PAYS IN THE PLAN YEAR (SEE PAGE 25)
- MAXIMUM PRESCRIPTION CO-PAY OF $20 FOR VOLUNTARY MAIL ORDER PROGRAM (SEE PAGE 25)
- THE HEALTH CARE SPENDING ACCOUNT HAS A NEW GRACE PERIOD TO INCUR EXPENSES (SEE PAGE 30)
- YOU MUST ENROLL IN FLEXIBLE SPENDING ACCOUNTS EVERY YEAR (ACTIVE EMPLOYEES ONLY) (SEE PAGE 30)

MARYLAND

FOUNDED 1634

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Cecilia Januszkiewicz
Secretary

Plan	Phone		Website
MEDICAL PLANS			
Aetna QPOS	1-800-501-9837	1-800-501-9837 (TTY/TDD)	www.aetna.com
CareFirst BlueCross BlueShield BlueChoice HMO	410-654-8675 (Baltimore) 1-800-445-6036 (within Maryland)		www.carefirst.com/statemd
CareFirst BlueCross BlueShield Maryland POS	State Operations Center 410-581-0021 (Baltimore) 1-800-203-2763 (outside Baltimore)	Open Enrollment Hotline 410-581-3602 (Baltimore)	www.carefirst.com/statemd
CareFirst BlueCross BlueShield PPO	State Operations Center 410-581-3601 (Baltimore) 1-800-225-0131 (outside Baltimore)	Open Enrollment Hotlines 410-581-3602 (Baltimore) 1-800-852-4463 (outside Baltimore)	www.carefirst.com/statemd
Kaiser Permanente HMO	1-800-777-7902 (Baltimore) 301-468-6000 (Washington)	301-816-3344 (TTY/TDD – Washington)	www.kaiserpermanente.org
M.D.IPA Preferred POS (MAMSI/UnitedHealthcare)	1-800-447-6267 301-360-8038	301-360-8111 (TTY/TDD) 1-800-553-7109 (TTY/TDD)	www.mamsiUnitedHealthcare.com
MLH – Eagle PPO (MAMSI/UnitedHealthcare)	1-800-447-6267 301-360-8038	301-360-8111 (TTY/TDD) 1-800-553-7109 (TTY/TDD))	www.mamsiUnitedHealthcare.com
Optimum Choice HMO (MAMSI/UnitedHealthcare)	1-800-447-6267 301-360-8038	301-360-8111 (TTY/TDD) 1-800-553-7109 (TTY/TDD)	www.mamsiUnitedHealthcare.com
MENTAL HEALTH/SUBSTANCE ABUSE PLAN (FOR MEMBERS IN PPO AND POS HEALTH PLANS — HMO MEMBERS USE HMO)			
APS Healthcare Bethesda Inc.	1-877-239-1458		www.APSHelpLink.com
PRESCRIPTION DRUG PLAN			
Pharmacy Benefits Manager	1-800-345-9384 (subject to change)		https://maryland.advancerx.com (subject to change)
DENTAL PLANS			
Dental Benefit Providers DHMO	1-877-566-3562		www.dbp-inc.com
United Concordia DHMO and DPPO	1-888-MD-TEETH (1-888-638-3384)		www.ucci.com (click on Clients' Corner and State of Maryland)
FLEXIBLE SPENDING ACCOUNTS			
SHPS	1-877-358-4276	Fax: 1-866-643-2219	www.shps.com
TERM LIFE INSURANCE PLAN			
The Standard Insurance Co.	1-888-246-9002		www.standard.com/mybenefits/maryland
ACCIDENTAL DEATH AND DISMEMBERMENT PLAN			
Metropolitan Life Insurance Co.	1-888-842-2757		www.metlife.com
LONG TERM CARE INSURANCE			
The Prudential Insurance Company of America	1-800-732-0416		www.prudential.com/gltc (group name: maryland; password: marylandltc)

EMPLOYEE BENEFITS DIVISION		
301 West Preston Street Room 510 Baltimore, MD 21201	410-767-4775 Fax: 410-333-7104 1-800-30-STATE (1-800-307-8283)	www.dbm.maryland.gov (click on Employee Services and Health Benefits)

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Attention

MEDICARE-ELIGIBLE PARTICIPANTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage through Medicare Part D. The State Prescription Drug plan coverage is creditable coverage compared to the Medicare Part D plan coverage. The State's prescription drug plan offers benefits that are as good, if not better, than the benefits available under the standard Medicare Part D coverage. Please refer to the Notice of Creditable Coverage section of this booklet, starting on page 50.

To enroll, call the Interactive Voice Response (IVR) system at:
410-669-3893 or 1-888-578-6434
TTY/TDD 410-333-5244
during open enrollment
24 hours a day, 7 days a week.

To enroll in Long Term Care Insurance, see page 38.

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Introduction

The State of Maryland provides a very attractive and generous benefit package to eligible employees and retirees, with a wide range of benefit options. The chart on the next page briefly outlines your benefit options for the 2006-2007 plan year (July 1, 2006 – June 30, 2007). For more details about each plan, review the sections in this book, or refer to the chart on the inside of the front cover for phone numbers and websites for each of the plans.

Benefit Chart Footnotes

* To be eligible, you must meet the eligibility requirements as outlined on pages 6-9 in this booklet.

** For retirees and their dependents who are Medicare eligible, all medical plans are supplemental to Medicare Parts A and B.

*** Effective January 1, 1995, only retirees who are enrolled in life insurance as an active employee at the time of retirement may continue life insurance coverage. Refer to page 34 for more details.

NOTICE TO EMPLOYEES AND THEIR DEPENDENTS

This booklet contains several very important Notices for every individual covered through the State Employee and Retiree Health and Welfare Benefits Program. These Notices inform you of your rights under State and Federal Laws on such important topics as Continuation of Coverage (COBRA), the Program's Privacy Practices, and Creditable Prescription Drug coverage. Please read all the notices carefully.

Plan	Options	Coverage	Who Is Eligible*
Medical	**PPO Plans** ◆ CareFirst BlueCross BlueShield ◆ MLH-Eagle (MAMSI/UnitedHealthcare) **POS Plans** ◆ Aetna ◆ CareFirst BlueCross BlueShield ◆ M.D.IPA Preferred (MAMSI/UnitedHealthcare) **HMO Plans** ◆ CareFirst BlueCross BlueShield BlueChoice ◆ Kaiser Permanente ◆ Optimum Choice (MAMSI/UnitedHealthcare)	Provides benefits for a variety of medical services and supplies. Benefit coverage level, exclusions and limitations, and allowable expenses vary by plan, so review the information carefully. All medical plan options provide benefits for routine vision care expenses. None of the medical plans include dental coverage.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees** ◆ ORP retirees**
Prescription Drug	Pharmacy Benefits Manager	Provides benefits for eligible prescription drugs.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees
Dental	◆ Dental Benefit Providers DHMO ◆ United Concordia DPPO ◆ United Concordia DHMO	Provides benefits for a variety of dental services and supplies.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees
Flexible Spending (SHPS)	◆ Health Care Spending Account ◆ Dependent Day Care Spending Account	Allows you to set aside money on a pre-tax basis to reimburse yourself for eligible health care or dependent day care expenses.	◆ Regular State/Satellite employees
Term Life (The Standard)	Coverage for you in increments of $10,000 up to $300,000 – may be subject to medical review Coverage for dependents in increments of $5,000 up to 50% of your coverage (to a maximum of $150,000) – may be subject to medical review	Pays a benefit to your designated beneficiary in the event of your death. You are automatically the beneficiary for your dependent's coverage.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees*** ◆ ORP retirees***
Accidental Death and Dismemberment (MetLife)	You may choose coverage for yourself equal to $100,000, $200,000, or $300,000 and coverage for your dependents equal to a percentage of your coverage	Pays a benefit to you or your beneficiary in the event of an accidental death or dismemberment. You are automatically the beneficiary for your dependent's coverage.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees
Long Term Care (The Prudential)	Choose from 4 different plans and for your chosen plan, select: ◆ 3- or 6-year facility benefit duration; and ◆ $2,500, $3,000, $4,500, or $6,000 facility monthly benefit amount	Provides benefits for long term care. Long term care is the type of care received, either at home or in a facility, when someone needs assistance with activities of daily living or suffers severe cognitive impairment.	◆ Regular State/Satellite employees ◆ Contractual State employees ◆ Less than 50% part-time State employees ◆ State retirees ◆ ORP retirees ◆ Other relatives

Benefit chart footnotes are on the previous page.

Enrollment Instructions

During Open Enrollment, you must use the Interactive Voice Response (IVR) system if you want to:

- Enroll in a new plan or make changes to your current benefits;
- Enroll in a Flexible Spending Account (FSA) – you MUST re-enroll each year (for Active/Satellite employees only); or
- Add or delete dependents.

To help you prepare for Open Enrollment, you will receive a personalized benefit statement with information about you and your benefit options for the 2006-2007 plan year.

- If you have never enrolled in any State health benefit plans, contact your Agency Benefits Coordinator. Retirees, call the Employee Benefits Division.
- If you did not receive a personalized benefits statement, please contact your Agency Benefits Coordinator. Retirees, call the Employee Benefits Division.
- If you are retiring on or before July 1, 2006, see your Agency Benefits Coordinator for a Retiree Enrollment Worksheet.

Before You Call the IVR System…

- Review this benefits book and have your personalized benefit statement handy when calling.
- Decide what changes and/or selections you want to make and note them on your personalized benefit statement.
- If you are an active employee, decide if you want to contribute to an FSA and if so, how much. If you want to participate this plan year, you must enroll even if you already participate.
  - Decide on the total amount you want deducted for the 2006-2007 plan year: _____
  - Calculate your per pay deduction by dividing the total amount by your number of pay periods during the year: _____ (Please note: Central Payroll employees will have 24 deductions. University employees who are 21-pay employees and Satellite employees should contact their Agency Benefits Coordinator to determine their number of deductions.)
- Have the following information ready if you are adding a dependent or making changes:
  - Dependent's full legal name
  - Dependent's Social Security Number
  - Dependent's gender
  - Dependent's relationship
  - Dependent's date of birth

How to Enroll

Now you are ready to enroll – follow the steps below:

STEP 1: Make the Call

Call the IVR system 24 hours a day, 7 days a week at the number below:

- Baltimore area: 410-669-3893
- Outside Baltimore area: 1-888-578-6434/ TTY: 410-333-5244

Enroll early! There is a large volume of calls the last few days of the Open Enrollment period. The best time to call is during the non-peak hours of late evening to early morning.

If you are enrolling in benefits for the first time or have cancelled benefits and are now re-enrolling, you will have to call one of the numbers shown above during office hours to have a benefit package created. To do this, press Option 8 when prompted to speak with an operator. Operators are available from 8:30 am to 4:30 pm, Monday through Friday except for State holidays and emergency situations. Once a benefit package has been created, you will be able to use the IVR system.

STEP 2: Make Your Selections

The IVR system will guide you through the steps for making selections and changes for:

- Medical;
- Prescription Drug;
- Dental;
- Accidental Death And Dismemberment;
- Flexible Spending Accounts;
- Term Life Insurance; and
- Adding/deleting dependents.

Did You Know…

If you do not want to enroll in benefits, make changes to your current benefits or dependent information, enroll in an FSA, or add or delete dependents, you do not need to call the IVR system – your benefits for the 2006-2007 plan year will be the same as your current benefits (with the exception of FSAs).

After you make each selection, the IVR system will confirm your selection.

If you are an active employee and need assistance using the IVR system, contact the Agency Benefits Coordinator in your Personnel Office. If you are a retiree and need assistance, contact the Employee Benefits Division during business hours.

STEP 3: Make Sure It's Right

To review your enrollment, call the IVR system again and select the appropriate option to listen to the changes you just made. This option will not repeat information about plans in which you did not make a change. Dependents added through "speak and spell" will not be available through this option. You will receive an updated summary statement of benefits within 10 days after your call.

- If you are an active employee, you will receive your statement from your Agency Benefits Coordinator.
- If you are a retiree, your statement will be mailed to the home address on our system for you.

Review your statement carefully to be sure that your selections for the 2006-2007 plan year are correct. If your selections are not correct, call the IVR system again to make the correct selections, or contact:

- Your Agency Benefits Coordinator, if you are an active employee; or
- The Employee Benefits Division, if you are a retiree.

No changes can be made after the Open Enrollment period ends.

If You Do Not Enroll

If you do not make changes to your benefits during the Open Enrollment period, you will have the same benefits for the 2006-2007 plan year that you currently have, with the exception of the FSAs. You must re-enroll for FSAs if you want to have coverage for the 2006-2007 plan year.

Also, see the Long Term Care (LTC) section of this booklet for more information on continuing your current LTC coverage with Unum.

Special Instructions

IF YOU ARE ADDING OR DELETING DEPENDENTS

- You will need to speak and spell each dependent's information clearly, so that it can be accurately entered into the system.
- You may need to change the coverage level of your plans if you add or delete a dependent; the system will not automatically change your coverage level.
- If you add a dependent, you will need to provide the required documentation to your Agency Benefits Coordinator within 30 days of the date you call the IVR system – if you do not, your dependent will be removed. Retirees should mail the required documentation to the Employee Benefits Division – see pages 10-11 for dependent documentation requirements.
- If you add an ineligible dependent to and/or fail to remove an ineligible dependent from your coverage, you will be required to pay the individual premium and full State subsidy for the ineligible dependent for each month that he or she remained enrolled. A dependent for whom you have not submitted the required documentation is an ineligible dependent.

IF YOU ARE ENROLLING IN LONG TERM CARE INSURANCE

The Prudential Insurance Company will administer the Long Term Care (LTC) plan beginning July 1, 2006. If you want to enroll in the new Prudential LTC plan, follow the instructions in the LTC section of this booklet. If you are currently enrolled in Unum LTC, please see the LTC section and the What's New – LTC section of this booklet for more information about your options.

What's New

Health Care Spending Account's New "Grace Period"

Under the pre-tax Health Care Spending Account offered by the State and administered by SHPS, there is now a 2½ months "Grace Period" to obtain reimbursement for eligible out-of-pocket health care expenses. So, now you have an extra 2½ months at the end of the plan year to incur eligible health care expenses before you have to forfeit any remaining funds.

This grace period applies to Health Care Spending Accounts for each plan year. For a 2006-2007 Health Care Spending Account, you can submit claims for eligible out-of-pocket health care expenses that you incur through September 15, 2007.

Example:	Under the Old Rule	With the New Grace Period
Annual Contribution	$1,200	$1,200
Eligible expenses through June 30	$1,000	$1,000
Eligible expenses July 1-September 15	$0	$250
Forfeited Amount	$250	$0
All claims must still be submitted by October 15		

Please note: This grace period does not apply to Dependent Day Care Spending Accounts. Therefore, for a 2006-2007 Dependent Day Care Spending Account, you can submit claims for day care services incurred through June 30, 2007. All Spending Account claims must be submitted by October 15, 2007.

New Long Term Care Insurance Carrier

The Prudential Insurance Company of America will be the new carrier for our Long Term Care Insurance Plan, beginning July 1, 2006.

Prudential will offer a special "Guaranteed Issue Period" for the new Long Term Care Insurance for eligible employees during the Spring 2006 Open Enrollment. This means that if you are a permanent State of Maryland/Satellite Account employee who works at least 20 hours per week, you will be able to enroll in the new plan **without** completing a medical questionnaire. You will not be turned down for Long Term Care Insurance coverage due to your health status if you enroll during this Open Enrollment only. To enroll in the plan, complete the Prudential enrollment form. Your coverage will begin on July 1, 2006.

If you do not enroll during this special "Guaranteed Issue" Spring 2006 Open Enrollment, you can enroll during future open enrollments or at any time. However, you will then need to complete a medical questionnaire. Prudential will review your medical questionnaire to determine if you qualify medically for the Long Term Care Insurance plan.

Retirees, contractual employees, State of Maryland/Satellite Account employees working less than 20 hours per week must provide proof of good health to Prudential and complete the Medical History & Insurability Form for Long Term Care Insurance. Spouses, dependent children, parents, grandparents, and other eligible relatives may also apply for Long Term Care Insurance coverage, and must complete the Prudential medical questionnaire, as well.

For further information, refer to the Long Term Care Insurance Plan section of this booklet. You can contact Prudential at their toll-free telephone number and visit their website (see the inside front cover of this booklet).

Your Options If You are Currently Enrolled in the Unum Long Term Care Plan

Effective July 1, 2006, the State will no longer offer the Unum Long Term Care Plan. It has been replaced by a new Long Term Care Plan through Prudential. For active employees, it means that your Unum Plan premium deductions will end in June 2006. If you are currently enrolled with Unum, you have several choices:

- **Keep your Unum Plan coverage** by paying your premiums directly to Unum. You will receive a letter from Unum about this conversion option and instructions for setting up a payment plan to continue your coverage. You must convert with Unum, or your coverage will end on June 30, 2006.
- **End your Unum Plan coverage** by not converting to an individual plan with Unum. Your Unum coverage would then end on June 30, 2006.
- **Enroll in the new Prudential LTC Insurance plan** offered through the State, with guaranteed issue during the Spring 2006 Open Enrollment for permanent active State of Maryland/Satellite Account employees working at least 20 hours per week. You will not need to complete a medical questionnaire (unless you are covering family members). All others will need to complete the Medical History & Insurability Form to be considered for LTC Insurance.
- **Have coverage through both plans.** To continue your Unum Plan coverage, you must convert to an individual Unum Plan policy, pay your premiums directly to Unum, and also enroll in the new Prudential LTC Insurance plan during Open Enrollment.

If you have further questions about your Unum conversion rights or if you have not received your conversion letter from Unum, please contact Unum at 1-800-227-4165.

For more information about the new Prudential Long-Term Care Insurance Plan, call Prudential at 1-800-732-0416 or visit their website at **www.prudential.com/gltc** (group name: maryland; password: marylandltc).

Prudential Long Term Care℠ Insurance is issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102, 1-800-732-0416. This coverage contains benefits, exclusions, limitations, eligibility requirements, and specific terms and provisions under which the insurance coverage may be continued in force or discontinued. The Prudential Insurance Company of America is authorized to conduct business in all U.S. states and the District of Columbia. All insurance policies/options may not be available in your state. Coverage for the State of Maryland Employee and Retiree Health and Welfare Benefits Program is issued under contract series 83500.

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New Prescription Mail Order Co-Pays Beginning July 1, 2006

If you use the Voluntary Mail Order Program, your co-pay for a 90-day supply of a maintenance prescription drug will not exceed $20. See page 25 for more information.

Benefits Overview

Who is Eligible

Certain employees and retirees are eligible for coverage. Refer to the following charts to determine if you are eligible for benefits from the State of Maryland and how you will pay for benefits. **If you are eligible,** you may also cover your eligible dependents for certain benefits.

Who You Can Cover

For plans in which you are enrolled, your eligible dependents may include:

- Your spouse;
- Your unmarried children – including a blood descendent of the first degree; a legally adopted child (including a child living with you during the period of probation); a stepchild permanently living in your household 100% of the time; and a child permanently living in the household of which you are the head, and the child is supported solely by you, provided you are related to the child by blood, marriage, or are the child's legal guardian. You can cover these children:
  - Through the end of the **calendar** year in which the child reaches age 19;*
  - Through the end of the **calendar** year in which the child reaches 23, if a full-time student taking 12 or more credit hours per semester and who is dependent on you for support; or the end of the month in which the child ceases to be a full-time student.*
- Children who are incapable of self-support because of mental or physical incapacity that began while the child was still otherwise eligible (see eligibility requirements above) and is living with you and dependent upon you for support.
- Beneficiaries of deceased retirees can only cover dependents who would be eligible dependents of the original retiree, if he or she were still living.

Refer to the Required Documentation For Dependents section for a list of documentation you must submit for all dependents.

* Please note: At the end of the calendar year, it is your responsibility to remove dependent children who turned 19 (or 23, if a full-time student) on or before December 31, 2006.

Important – Duplicate Coverage Prohibited

A husband and wife who are both active State employees and/or retirees may not have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of two State employees and/or retirees may not be covered twice under both parents' plans. It is the employee's/retiree's responsibility to make sure that they or their dependents do not have duplicate State coverage.

Your Cost

The amount you pay for benefits coverage depends on several factors including:

- The benefit plans you choose;
- Who you choose to cover;
- Your age (for Life Insurance and Long Term Care Insurance only);
- Your Medicare eligibility (for retiree medical benefits only);
- Your status (full-time active, part-time active, retiree, etc.); and
- Your length of State service (for retirees only).

If you are eligible for the full State subsidy, you pay the amount shown on the premium rate chart. However, some individuals will receive no State subsidy or only a percentage of the State subsidy and will be responsible for the amount shown on the premium rate chart plus the difference between the full State subsidy and the percentage for which he or she is eligible to receive, if any.

Eligibility	Subsidy Amount	How You Will Pay for Benefits
ACTIVE EMPLOYEES		
You are eligible for benefits if you are: ◆ A full-time or part-time (working 50% or more) State employee who is regularly paid salary or wages through an official State payroll center, including but not limited to: – Central Payroll Bureau; – Mass Transit Administration; and – University of Maryland, including graduate assistants and the University's Far East and European Divisions; ◆ An elected State official; ◆ Register of Wills or an employee of Register of Wills; ◆ Clerk of the Court or an employee of the offices of Clerks of the Court; ◆ A State Board or Commission member who is regularly paid salary or wages and works at least 50% of the work week; ◆ An employee of a political subdivision which participates in the State's health benefits program with the approval of the governing body; or ◆ An employee of an agency, commission, or organization permitted to participate in the State's health benefits program by law.	Full State Subsidy	Through payroll deductions, using pre-tax deductions through the State's cafeteria plan, where pre-tax deductions are permitted.
CONTRACTUAL AND PART-TIME (WORKING LESS THAN 50%) EMPLOYEES		
You are eligible to enroll in the same benefits as full-time State employees, with the exception of the Flexible Spending Accounts and Long Term Care Insurance. Contractual and part-time employees must follow the same participation rules as full-time employees, except: ◆ You cannot change the effective date of coverage once the enrollment worksheet has been processed (a letter must be attached with the worksheet if you are requesting an effective date other than the current processing date); and ◆ Changes to coverage cannot be made at the time of a contract renewal.	No State Subsidy – you pay the full amount	You will receive payment coupons in the mail and should send your premium payments with the payment coupon to the address provided on your coupon payment letter. Your benefits will be effective as of the date noted on your letter, but no claims will be paid until the Employee Benefits Division receives your premium payment. Payments are due the first of every month, with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received or postmarked by the end of the 30-day grace period, you will be disenrolled and may not re-enroll until the next Open Enrollment period. Payment deadlines are strictly enforced. If you do not receive payment coupons within one month of signing your enrollment worksheet, please contact your Agency Benefits Coordinator.

Eligibility	Subsidy Amount	How You Will Pay for Benefits
MARYLAND STATE RETIREMENT SYSTEM RETIREES		
You are eligible for benefits if you are a State retiree who is currently receiving a monthly State retirement allowance and meet one of the following criteria: ◆ You left State service with at least 16 years of creditable service with the State; ◆ You retired directly from State service with at least five years of creditable service with the State; ◆ You left State service (deferring your retirement allowance) with at least 10 years of State creditable service and within five years of normal retirement age; ◆ You retired directly from State service with a disability retirement allowance; or ◆ Your State employment ended before July 1, 1984. Please note: Retirees of a County that participates with the State Retirement System are not eligible for health benefits coverage through the State Employee and Retiree Health and Welfare Benefits Program. Certain other retirees, such as retirees of the Maryland Environmental Service or the University of Maryland Medical System that receive a State retirement allowance may be eligible. Contact your Agency Benefits Coordinator or the Employee Benefits Division if you think you may be eligible.	Full State Subsidy if: ◆ You retire with 16 or more years of State creditable service; ◆ You receive a disability retirement; or ◆ You retired from State service before July 1, 1984. Partial State Subsidy if you have at least five years of State creditable service, but less than 16. For example, if you have 10 years of State creditable service, you would receive 10/16 of the full State subsidy.	Premiums will be deducted from your monthly retirement allowance. If your retirement allowance is not large enough to cover any or all of your monthly premiums, you will be billed for the plan premiums that could not be deducted. Partial plan premiums will not be deducted. You will receive coupons for the 12-month period of July-June in August for the premiums that were not deducted from your monthly retirement allowance. Premium payments are due on the first of every month, with a 30-day grace period (exception: July premiums are due upon receipt of the coupons, with a 30-day grace period). If payment is not received by the end of the grace period, you will be disenrolled from the plans for which payments were not received and will not be permitted to re-enroll until the next Open Enrollment period.
BENEFICIARIES OF DECEASED MARYLAND STATE RETIREMENT SYSTEM RETIREES		
You are eligible for benefits if you are a surviving spouse or child of a deceased State retiree and: ◆ Are receiving a monthly State retirement allowance as the surviving beneficiary of a deceased retiree; and ◆ Meet the dependent eligibility criteria for health benefits. If the surviving spouse is the beneficiary, the spouse may cover herself/himself and eligible dependents. You may only cover dependents that would be eligible dependents of the deceased retiree if he or she were still living. If the beneficiary is a child, the child will only be eligible for subsidized health benefits as long as he or she meets the dependent eligibility requirements for children (see page 6). When the child no longer meets the dependent eligibility criteria for children, the subsidized health benefits end. Non-subsidized benefits under COBRA are available for up to 36 months. If you were enrolled in dependent Term Life Insurance at the time of the retiree's death, that policy must be converted through the Term Life Insurance Plan within 30 days to continue Term Life Insurance coverage. Plan names and phone numbers are located on the inside cover of this booklet.	If you are eligible for coverage as a beneficiary, you will receive the same State subsidy that the retiree was entitled to receive at the time of his or her death. See above section.	Same as Maryland State Retirement System Retirees (see above).

Be sure to notify the Employee Benefits Division in writing of any address changes in order to receive information about your benefits from The Division, as well as the plans to which you are entitled.

Eligibility	Subsidy Amount	How You Will Pay for Benefits
OPTIONAL RETIREMENT PROGRAM (ORP) RETIREES		
There are special rules governing your eligibility and costs for health benefits if you are a retiree of an Optional Retirement Program (ORP), including Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF), Valic, Aetna, and American Century. You are eligible for benefits if you are an ORP retiree, you are receiving a periodic distribution from your ORP account, and you: ◆ Had at least five years of State service with a Maryland State institution of higher education and retired directly from State service; ◆ Ended State service with a Maryland State institution of higher education with at least 10 years of State service and were at least age 57; or ◆ Ended service with a Maryland State institution of higher education with at least 16 years of State service.	◆ Full State Subsidy if you have at least 16 years of service with a State institution of higher education **and** retire directly from service with the State institution of higher education ◆ Partial State Subsidy if you have at least 5 but less than 16 years of service with a State institution of higher education **and** retire directly from service with the State institution of higher education ◆ No State subsidy for ORP retirees who did not retire directly from a State institution of higher education If you are an ORP retiree with at least 25 total years of service with the State, you are not required to retire directly from a Maryland State institution of higher education in order to participate in the Health Benefits Program with the full State subsidy.	You will receive a letter along with payment coupons, which must be submitted with the premium payments. Benefits will be effective as of the date noted on your letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupons received, but must be made in full monthly increments. If payment is not received or postmarked by the end of the grace period, benefits will be cancelled. If benefits are cancelled, you may re-enroll during the next Open Enrollment period. Payment deadlines are strictly enforced.
BENEFICIARIES OF DECEASED ORP RETIREES		
You are eligible for health benefits coverage if you are the surviving spouse or child of a deceased ORP retiree and: ◆ You are receiving a periodic distribution of benefits from the retiree's ORP; and ◆ You meet the dependent eligibility criteria for health benefits. If the surviving spouse is the beneficiary, the spouse may cover himself/herself and eligible dependents. You may only cover dependents that would be eligible dependents of the deceased ORP retiree if he or she were still living. If a child is the beneficiary, only the child will be eligible for health benefits as long as he or she meets dependent eligibility requirements for children (see page 6).	◆ Full State Subsidy if the retiree had at least 25 years of service with the State ◆ No State Subsidy if the retiree had less than 25 years of State service	Same as ORP Retirees (see above).

Required Documentation for Dependents

You are required to submit documentation for each dependent you wish to enroll for coverage. The following chart lists the documents you must submit to enroll a dependent. Photocopies are acceptable. An official translator other than the employee/retiree or spouse (available at any college or university) must translate foreign documents into English. The translated document must be signed by the translator and notarized.

Required Documentation for Spouse	
Spouse	To add a spouse: ◆ State official marriage certificate (must be certified and dated by the appropriate State or County official, such as the Clerk of Court): – From the court in the County or City in which the marriage took place; or – From the Maryland Division of Vital Records for marriages that occurred at least six months prior; or – From the Department of Health and Mental Hygiene (DHMH) website: www.dhmh.maryland.gov (click on Online Services) – also www.vitalchek.com To remove a spouse from your plan outside of the Open Enrollment period: ◆ Limited divorce, legal separation decree (must be signed by a judge); or ◆ Divorce decree (must be signed by a judge) Please note: A separation order or agreement is not a change in family status permitting a mid-year change in benefit elections.
Required Documentation for Unmarried Children	
Natural/ Biological Child	◆ Natural/Biological child's official State birth certificate (which must show the State employee/retiree as parent); and ◆ Tax affidavit
Adopted Child	Pending adoption: ◆ Notice of placement for adoption provided on adoption agency letterhead or copy of court order placing child pending final adoption; and ◆ Tax affidavit After adoption: ◆ Copy of final adoption decree signed by a judge or a State-issued birth certificate (showing the State employee/retiree as the parent); and ◆ Tax affidavit Please note: For foreign adoptions, documentation of entry into United States is also required and all documentation must be translated into English, signed by the translator, and notarized.
Stepchild (must reside with the employee/ retiree 100%)	◆ Copy of child's official State birth certificate (must indicate spouse as parent); ◆ Copy of official State marriage certificate (must be certified and dated by the appropriate State or County official, such as the Clerk of Court); ◆ Applicable divorce decree or legal custody papers; ◆ State affidavit for step-children; and ◆ Tax affidavit Please note: If no divorce decree or custody papers are available, you must attach proof of the stepchild's residence with the employee/retiree (e.g., school records, driver's license, day care records, etc.).
Legal Ward	◆ State affidavit certifying permanent residence and support; ◆ Tax affidavit; and ◆ Either: – Copy of court order signed by a judge or other court official confirming that the employee/retiree has permanent legal custody of the child by a court order of custody or guardianship; or – Copy of will providing testamentary appointment, confirming that the employee/retiree has legal custody of the child

Required Documentation for Unmarried Children (continued)	
Grandchild And Other Dependent Child Relatives	◆ Copy of child's official State birth certificate; ◆ State affidavit certifying residence and sole support; ◆ Tax affidavit; and ◆ Either: – Proof of relation by blood (copy of child's parent's and other relative's official State birth certificate(s) to show relationship to employee/retiree) or by marriage (copy of official marriage certificate(s) (must be certified and dated by the appropriate State or County official, such as the Clerk of Court) to show relationship to employee/retiree); or – Copy of guardianship order showing the employee/retiree is the child's legal guardian
Medical Child Support Order	Copy of court order requiring employee/retiree to provide support and health coverage, signed by the child support officer or judge
Disabled Child	In addition to the required documentation for a dependent child, a physician certification/verification of permanent disability that began while the child was still otherwise eligible Please note: The child will not be added until the disability certification is approved. Verification of the disability will be required every two years, regardless of the nature of the disability.
Dependents Age 19-23 (after the end of the calendar year in which the child turns 19 through the end of the calendar year the child turns 23)	In addition to the required documentation for a dependent child, certification of student status (certification will be required once a year in September) Please note: We cannot accept copies of school bills, acceptance letters, or pre-registration as student certification. The certification must either be on school letterhead signed by the registrar's office or on the full-time certification form (available on the Employee Benefits Division website at www.dbm.maryland.gov. Click on Employee Services, and then Health Benefits).

When Coverage Begins

If you enroll in benefits during the Open Enrollment period, the coverage you elect will begin July 1, 2006 and remain in effect through June 30, 2007, unless you have a qualifying status change that allows you to make a mid-year change in coverage as described under Enrollment and Changes Outside of Open Enrollment (see page 12).

If you enroll in benefits at a time other than during the Open Enrollment period, refer to the chart below to see when your coverage begins.

If you are...	Coverage becomes effective...
A new active employee enrolling for the first time	Either the 1st or 16th of the month, based on the pay period for which the first deduction is taken.
An active employee making an authorized mid-year change in coverage	Either the 1st or 16th of the month, based on the pay period for which the first deduction is taken.
Newly retired and enrolling for retiree benefits for the first time	1st of the month, based on the month in which the first deduction is taken or when payment is received for direct pay enrollees.
A retiree making an authorized mid-year change in coverage	1st of the month, based on the month in which the first deduction is taken or when payment is received for direct pay enrollees.

You may purchase coverage retroactively to the date you or your dependent became eligible for coverage on a post-tax basis, or back to the date of the change in circumstances permitting a mid-year change in coverage, whichever is later. See your Agency Benefits Coordinator or call the Employee Benefits Division for more information.

New retirees should receive a retroactive adjustment letter from the Employee Benefits Division regarding any missed premiums between their date of retirement and the period covered by their first retiree premium deduction.

You may not retroactively cancel coverage.

Enrollment and Changes Outside of Open Enrollment

Regardless of how you pay for your coverage (by automatic deduction or with payment coupons), the State uses the same rules to permit changes outside of Open Enrollment. IRS regulations for cafeteria plans strictly govern when and how payroll deductions for benefits can be changed.

Due to IRS regulations, you are generally only permitted to make changes to your coverage during the Open Enrollment period each year. However, there are some changes in status that permit you to make changes mid-year. Examples of qualifying changes in status include:

- A birth of a child;
- Death of a dependent;
- Dependent's loss of eligibility;
- Marriage or divorce;
- Moving outside of a network area;
- Involuntary loss of other coverage;
- Gaining eligibility for Medicare (for retirees); or
- Open Enrollment for your other coverage.

You have 60 days from the date of the qualifying change in status to submit an enrollment worksheet to make changes to your benefits. Any changes submitted after 60 days of the qualifying change in status will not be processed, and you will have to wait until the next Open Enrollment period to make a change.

For more information about enrollment and changes outside of Open Enrollment, contact:

- **Your Agency Benefits Coordinator, if you are an active employee; or**
- **The Employee Benefits Division, if you are a retiree.**

Removing Your Ex-Spouse and Other Dependents Who Lose Eligibility

Ex-Spouse

You must file an enrollment worksheet to remove your ex-spouse as soon as you are divorced. The ex-spouse cannot be continued on your State benefits coverage. If you fail to remove your ex-spouse within 60 days of your divorce, you will be required to pay the insurance premium plus the State subsidy from the date of the divorce. You may also face disciplinary action, termination of employment, and/or criminal prosecution.

If you are obligated through terms of the divorce to provide health insurance coverage for the ex-spouse, that coverage can be provided for a limited time under COBRA and Maryland law. If COBRA is selected, the ex-spouse will have his or her own account and will be responsible for paying premiums directly. COBRA coverage is not subsidized by the State. Please see the Continuation of Coverage section for more information.

Other Dependents

It is your responsibility to file an enrollment worksheet to remove any other dependents as soon as they lose dependent eligibility due to: being over the eligibility age, marriage, loss of student status, no longer residing with you, a denied disability certification, becoming ex-step-children (children of your ex-spouse regardless of residence), etc.

If you fail to remove a dependent when they become ineligible, you will be required to pay the insurance premium plus the State subsidy from the date they became ineligible. You may also face disciplinary action, termination of employment, and/or criminal prosecution. In most cases, removed dependents are entitled to COBRA coverage for a limited time, which is not subsidized by the State. Please see the Continuation of Coverage section for more information.

Making Changes

Refer to the chart below for instructions on how to make mid-year changes.

If You...	Then...
Are an active State employee enrolling for the first time	You must file an enrollment worksheet within 60 days of your hire date. Applications will not be accepted after 60 days. The Agency Benefits Coordinator must sign the enrollment worksheet and check the accuracy of the dependent verification documentation before forwarding to the Employee Benefits Division. If you want coverage to begin at the date of hire, you must contact your Agency Benefits Coordinator within 30 days after receiving your first payroll deduction for benefits to request a retroactive adjustment and pay your portion of the missed premiums.
Are enrolling as a new retiree	You must file an enrollment worksheet within 60 days of your retirement date. (If your retirement date is retroactive, you must file an enrollment worksheet within 60 days of receiving your first retirement allowance.) Submit the worksheet to the Employee Benefits Division along with the required documentation. You should receive a retroactive adjustment letter from the Employee Benefits Division regarding any missed premiums between your retirement date and the period covered by your first retiree premium deduction.
Are an active employee or retiree making a change in coverage	You must file an enrollment worksheet to change the coverage within 60 days of a qualifying event (e.g., birth, marriage, death, over-age dependent, divorce, etc.). Active employees must submit their enrollment worksheet to their Agency Benefits Coordinator. The Agency Benefits Coordinator must sign the enrollment worksheet and check the accuracy of the dependent verification documentation before forwarding to the Employee Benefits Division. Retirees should submit their worksheet to the Employee Benefits Division, along with the required documentation.
Experience a qualifying event	In order for your change to be effective on the day of the qualifying event, you must submit a retroactive adjustment. If your qualifying event changes your coverage level, you should submit a retroactive adjustment form within 30 days of the first payroll deduction change. Even if the qualifying event does not change your coverage levels, a zero-balance retroactive adjustment is still required. Active employees must contact their Agency Benefits Coordinator. Retirees must contact the Employee Benefits Division. **Only the Employee Benefits Division has authority to modify the changes to your health benefits that you request.**
Have a newborn child that you want to add to your health benefits	You must add your child within 60 days from the date of birth. If a newborn is not added within 60 days of the birth, you must wait until the next Open Enrollment period to enroll the child. You must file an enrollment worksheet and retroactive adjustment form even if you already have family coverage. You must submit temporary documentation of the child's birth (such as hospital discharge papers, copy of the child's hospital I.D. bracelet, or footprints) with the worksheet. An official State birth certificate must be submitted within 60 days of the date of receipt of the temporary documentation. Active employees should meet with their Agency Benefits Coordinator. All other enrollees should call the Employee Benefits Division for assistance.
Need to remove an ineligible dependent (e.g., divorced spouse, child no longer eligible, etc.)	You must notify the Employee Benefits Division in writing through an enrollment worksheet. You must include all necessary documentation with your notification. If you do not delete ineligible dependent within 60 days of the qualifying event, you will be responsible for the total premium cost for coverage of the ineligible dependent, regardless of whether claims were submitted or paid. In addition, keeping an ineligible dependent on your coverage may result in disciplinary action, termination of employment, and/or criminal prosecution.

When Coverage Ends

You may choose to end your coverage during the Open Enrollment period or as a result of having a qualifying status change allowing you to terminate coverage mid-year.

- If you end coverage during the Open Enrollment period, your coverage will end on June 30.
- If you end coverage as a result of a qualifying status change, the date your coverage ends will be determined by the time period covered by your last deduction.

It is your responsibility to verify your benefit deductions on your check or retirement stub as well as your summary statement of benefits to make sure they match the coverage you requested. If there is an error or omission in your deductions, you should immediately (at least within 30 days) contact:

- Your Agency Benefits Coordinator, if you are an active employee; or
- The Employee Benefits Division, if you are a retiree.

Special Note for Active Employees

Your effective date of coverage depends on the pay period ending date for which a deduction is taken from each paycheck. The pay period ending date is shown on the check stub of each paycheck. Paychecks are distributed approximately one week after the pay period ending date.

If you miss any premium deductions because of an unpaid absence, you must pay all missed premiums including the State subsidy (if applicable) or your coverage will be cancelled for the remainder of the plan year. Missing one or two pay periods is considered a short term leave of absence. Please review the policy in the Continuation of Coverage section. The Employee Benefits Division will bill you for missed premiums and the payment deadline is strictly enforced.

If you missed deductions because you transferred between two agencies or have a payroll error, please contact your Agency Benefits Coordinator immediately so that your Coordinator can calculate your share of the premiums and submit a retroactive adjustment form. This must be done so that your benefits are not cancelled.

If your benefits are cancelled, you will be permitted to re-enroll during the next Open Enrollment period.

Refunds

A refund request for any reason other than an administrative error by a State agency cannot be approved. Examples of refund requests that will be denied include:

- An incorrect coverage level due to:
  - Dependent no longer being eligible;
  - Divorce; or
  - Change in Medicare status;
- Incorrect benefits due to error in the enrollment worksheet or incorrect use of the IVR during the Open Enrollment period; or
- Incorrect deductions for changes that were not made within 60 days of the qualifying change in status.

Medical Benefits *(including routine vision and mental health coverage)*

Your Choices

You have eight medical plans from which to choose:

- **2 Preferred Provider Organization (PPO) Plans:**
  - CareFirst BlueCross BlueShield; and
  - MLH-Eagle (MAMSI/UnitedHealthcare);
- **3 Point-of-Service (POS) Plans:**
  - Aetna;
  - CareFirst BlueCross BlueShield; and
  - M.D.IPA Preferred (MAMSI/UnitedHealthcare);
- **3 Health Maintenance Organization (HMO) Plans:**
  - Carefirst BlueCross BlueShield BlueChoice;
  - Kaiser Permanente; and
  - Optimum Choice (MAMSI/UnitedHealthcare).

In general, all options under each type of plan (PPO, POS, or HMO) cover the same benefits. However, the participating provider networks for the medical plans will be different. Be sure to carefully review what's covered by each type of plan, as well as which providers and facilities participate with the various plan networks.

How the Plans Work

Once you enroll in a medical plan, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. It is your responsibility to select the plan that best suits your needs.

Preferred Provider Organization (PPO) Plans

The PPO Plans allow you to choose any doctor you want at the time of service – you do not have to choose a primary care physician up front or get referrals. Simply present your ID card to the provider.

In-Network

If your doctor is a participating physician in the PPO network, you will pay a co-pay at the time of service. The co-pay will be $15 for a primary care physician or $25 for a specialist. For other co-pays, see the Standard Benefits for Medical Plans chart.

Out-of-Network

If the doctor is not a participating physician in the PPO network, you may have to pay the entire fee at the time of service and submit a claim for reimbursement. This amount will be applied toward your plan year deductible ($250/individual, $500/family). After you have reached your deductible, your PPO plan will pay 80% of the plan's allowed amount. You are responsible for the remaining 20% of the allowed amount, as well as any fees above the plan's allowed amount, up to the non-PPO physician's charge.

Point-of-Service (POS) Plans

The POS plans are managed care plans. You may receive services in- or out-of-network, but you will pay more for out-of-network services. When you enroll, you must choose a primary care physician (PCP) for all in-network services.

In-Network

If you receive care from your PCP or through a referral from your PCP, you only pay the required co-pay at the time of service. The co-pay will be $15 for a primary care physician or $25 for a specialist. For other co-pays, see the Standard Benefits for Medical Plans chart.

There are no pre-existing condition clauses for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.

Out-of-Network

You also may choose to receive treatment out-of-network without obtaining preauthorization from your PCP. This is called "self-referral." The POS option gives you the freedom to choose your own provider, subject to payment of an upfront deductible ($250/individual, $500/family) per plan year and 20% coinsurance for out-of-network services, plus any amount up to the non-POS physician's charge.

Health Maintenance Organization (HMO) Plans

The HMO plans are managed care plans and only cover in-network benefits (except in the event of an emergency). If you enroll in this type of plan, you must choose a primary care physician (PCP). In order to receive benefits, you must receive services from your PCP or through a referral from your PCP, with the exception of routine gynecologist (GYN) visits within the network once every 12 months.

In-Network

When you receive services in-network from your PCP, you will pay a $15 co-pay. If your PCP and plan authorize care from a specialist, your co-pay will be $25.

Out-of-Network

There are no benefits for out-of-network services. You will be responsible for the full charge.

Standard Benefits for Medical Plans

The following chart is a summary of generally available benefits and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a description of coverage book from the plan in which you enroll that will provide details on your plan coverage. The percentages referred to in this chart are percentages the plan will pay based upon the plan's maximum allowed amount. A non-participating out-of-network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	HMO In-Network Only
Deductibles					
Individual	None	$250	None	$250	None
Family	None	$500	None	$500	None
Out-of-Pocket Coinsurance Maximums					
Individual	None	$3,000	None	$3,000	None
Family	None	$6,000	None	$6,000	None
	Any fees above the plan's Allowed Amount are not counted toward the out-of-pocket maximum.				
Lifetime Maximums	$2 million per lifetime per person		$2 million per lifetime per person		Unlimited
HOSPITAL — INPATIENT SERVICES					
Inpatient Care (requires preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Inpatient care primarily for or solely for rehabilitation is not covered.				
Hospitalization	100% for 365 days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Anesthesia	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Surgery (requires preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Organ Transplants (requires preauthorization)					
Per calendar year for cornea, kidney, and bone marrow	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Per 365 days up to $1 million per heart, heart-lung, single or double lung, liver, and pancreas	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
HOSPITAL — OUTPATIENT SERVICES					
Chemotherapy/ Radiation	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Diagnostic Lab & X-Ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Outpatient Surgery (requires preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Anesthesia	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Benefit	PPO In-network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	HMO In-Network Only
THERAPIES					
Benefit Therapies (see below for further information on therapies)	100% after $25 co-pay when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% after $25 co-pay when preauthorized by Plan
Physical Therapy (PT) and Occupational Therapy (OT)	PT/OT services must be pre-certified after the 6th visit, based on medical necessity; 50 visits per plan year combined for PT/OT/Speech Therapy				
Speech Therapy	Must be pre-certified from the first visit with exceptions and close monitoring for special situations (e.g., trauma, brain injury) for additional visits				
COMMON AND PREVENTIVE SERVICES					
Physician's Primary Care Office Visit	100% after $15 co-pay	80% after deductible	100% after $15 co-pay	80% after deductible	100% after $15 co-pay
Specialist Office Visit	100% after $25 co-pay	80% after deductible	100% after $25 co-pay	80% after deductible	100% after $25 co-pay
Routine Annual GYN Exam (including Pap test)	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	80% after deductible	100% after $15 co-pay when preauthorized by Plan
Hearing Examinations and Hearing Aids	100% after $15 co-pay for exam 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	80% after deductible for exam 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	100% after $15 co-pay for exam when preauthorized by Plan 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent	Not covered, except for hearing aids as mandated for minor children (ages 0-18) as mandated by Maryland Law effective 01/01/02	100% after $15 co-pay for exam when preauthorized by Plan 100% for Basic Model Hearing Aid 1 exam and hearing aid per ear every 3 years for each employee and dependent
	Includes mandated benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland Law effective 01/01/02, including hearing aids per each impaired ear for minor children. Call your plan for the maximum covered amount.				
Immunizations* Flu shots not covered	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Mammography**	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Physical Exams	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	Not covered	100% after $15 co-pay when preauthorized by Plan
	One exam every three years for all members and their dependents age 13 and older; contact plan for further details on time eligibility for physical exams				
Well Baby Care Birth–2 years: 8 visits total 2–12 years: 1 visit per plan year	100% after $15 co-pay per visit, to age 12	80% after deductible per visit, to age 12	100% after $15 co-pay per visit, to age 12 when preauthorized by Plan	Not covered	100% after $15 co-pay per visit, to age 12 when preauthorized by Plan
	Contact plan for further details on eligibility for visits.				
Allergy Testing	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist)	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan

Benefit chart footnotes are on page 21.

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	HMO In-Network Only
Flu Shots	Not covered	Not covered	Not covered	Not covered	Not covered
EMERGENCY TREATMENT					
Ambulance Services	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies
Emergency Room (ER) Services – inside and outside of service area***	100% after $50 co-pay for ER Facility Care and $50 co-pay for ER Physician Services	100% after $50 co-pay for ER Facility Care and $50 co-pay for ER Physician Services	100% after $50 co-pay for ER Facility Care and $50 co-pay for ER Physician Services	100% after $50 co-pay for ER Facility Care and $50 co-pay for ER Physician Services	100% after $50 co-pay for ER Facility Care and $50 co-pay for ER Physician Services
	Co-pays are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowed amount, plus the two $50 co-pays.				
MATERNITY					
Maternity Benefits	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Newborn Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Contact your plan to confirm if your hospital's Neonatal Unit participates in the plan. If the Neonatal Unit and its physicians do not participate with the plan, you will be responsible for any balances up to the charge of the Neonatal Unit's providers. The plan will only pay these providers under the out-of-network coverage benefits (newborn children must be enrolled within 60 days of birth).				
OTHER SERVICES AND SUPPLIES					
Acupuncture Services for Chronic Pain Management	100% after $20 co-pay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Cardiac Rehabilitation†	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chiropractic Services	100% after $20 co-pay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Dental Services	Not covered	Not covered	Not covered	Not covered	Not covered
Diabetic Nutritional Counseling, as mandated by Maryland Law	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	80% after deductible	100% after $15 co-pay when preauthorized by Plan
Durable Medical Equipment	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Contact plan for details on covered items.				
Extended Care Facility (if medically necessary)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Skilled nursing care and extended care facility benefits are limited to 180 days per plan year as long as skilled nursing care is medically necessary. Inpatient care primarily for or solely for rehabilitation is not covered.				
Family Planning And Fertility Testing	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Family Planning benefits include: sperm count hysterosalpingography, eudiometrical biopsy, IUD insertion, vasectomy, and tubal ligation. Only one reversal covered per lifetime.				
Home Health Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Home Health Care benefits are limited to 120 days per plan year.				
Hospice Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Benefit chart footnotes are on page 21.

Benefit	PPO In-Network	PPO Out-of-Network	POS In-Network	POS Out-of-Network	HMO In-Network Only
In Vitro Fertilization (IVF) and Artificial Insemination (AI)[††] Contact your plan for further details	100% for up to 3 attempts of AI and 3 attempts of IVF per live birth, per lifetime	80% after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, per lifetime	100% when preauthorized by Plan for up to 3 attempts of AI and 3 attempts of IVF per live birth, per lifetime	80% after deductible for up to 3 attempts of AI and 3 attempts of IVF per live birth, per lifetime	100% when preauthorized by Plan for up to 3 attempts of AI and 3 attempts of IVF per live birth, per lifetime
Medical Supplies	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
	Includes, but not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns, or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment and machines; and all diabetic supplies as mandated by Maryland law.				
Mental Health/ Substance Abuse See the Mental Health/ Substance Abuse Benefits section for more information (does not apply to HMOs)	Not covered by Plan Covered by State's Mental Health Plan	Not covered by Plan Covered by State's Mental Health Plan	Not covered by Plan Covered by State's Mental Health Plan	Not covered by Plan Covered by State's Mental Health Plan	Inpatient care: 100% for up to 365 days when preauthorized by Plan Outpatient care: 80% for visits 1-5; 65% for visits 6-30; 50% for visits 31+ per calendar year
	See pages 22-24 for mental health benefits.				
Norplant Surgery Only	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Prescription Drugs	Not covered	Not covered	Not covered	Not covered	Not covered
Private Duty Nursing (must be preauthorized by all Plans)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Surgical Second Opinion	100%	100%	100%	100%	100% when preauthorized by Plan or when required by Plan
Urgent Care Centers	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay
Whole Blood Charges	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
VISION SERVICES AND SUPPLIES					
Vision – Medical Any services that deal with the medical health of the eye	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist)	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan
Vision – Routine Any services that deal with correcting vision (provided by your health plan)	**Exam:** Plan pays up to $45 (available once every plan year) **Prescription lenses** (per pair – available once every plan year): ◆ Single vision: $28.80 ◆ Bifocal, single: $48.60 ◆ Bifocal, double: $88.20 ◆ Trifocal: $70.20 ◆ Aphakic – glass: $54.00 ◆ Aphakic – plastic: $126.00 ◆ Aphakic – aspheric: $162.00			**Frames:** Plan pays up to $45 (available once every plan year) **Contacts** (per pair, instead of frames and lenses – available once every plan year): ◆ Medically necessary: $201.60 ◆ Cosmetic: $50.40	
	You may obtain vision services from any licensed vision provider, whether in your health plan's network or not. However, you may have to pay the full cost up front and submit a claim form to your health plan for partial reimbursement. To obtain vision benefits, you must contact your medical plan for more information. Vision benefits are available once every plan year.				

Benefit chart footnotes are on page 21.

Benefit Chart Footnotes

* Immunizations are only covered as recommended by the American Medical Association and the American Academy of Pediatrics. The immunization benefit covers immunizations required for participation in school athletics and Lyme Disease immunizations when medically necessary. Contact your plan for more details.

** Certain age restrictions and timeframes apply for screening mammograms. Coverage for screening mammograms varies by age: one baseline (age 35-39); one mammogram every 2 years (40-49); one per year (50+). Diagnostic mammograms have no age limitations. Call your plan to check on your next eligible date.

***Emergency services or medical emergency: health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- Placing the patient's health in jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

† Cardiac rehabilitation benefits: 36 sessions in a 12-week period (or on a case-by-case basis thereafter) with physician supervision and in a medical facility. Cardiac rehabilitation must be medically necessary with a physician referral, and with history of: heart attack in past 12 months; Coronary Artery Bypass Graft (CABG) surgery; angioplasty; heart valve surgery; stable angina pectoris; compensated heart failure; or heart and lung transplants. Inpatient care primarily for rehabilitation is not covered.

†† In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (as recognized by the laws of Maryland) woman if:

- She was infertile throughout the most recent two years of marriage to the same man; or
- Her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or
- Male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with her spouse's sperm. IVF and AI are covered for a maximum of three attempts per procedure.

- Coverage of the three IVF attempts per live birth will not exceed a maximum expense of $100,000 per lifetime.
- The AI attempts must be taken, when medically appropriate, before IVF attempts will be covered.

This is only a summary. Contact your plan for further details on preauthorization requirements.

For More Information

If you have questions about the plans, refer to the inside cover of this book for phone numbers and websites for each of the benefit providers. You may also contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE.

Mental Health/Substance Abuse Benefits

Your Choices

If you enroll in a State medical plan, you and your enrolled dependents will automatically receive mental health and substance abuse plan coverage.

If you are enrolled in...	Your mental health and substance abuse benefits are managed by...
HMO plan	The HMO plan
PPO or POS plan	APS Healthcare Bethesda, Inc. (APS)

However, your mental health and substance abuse benefits vary depending on the medical plan in which you are enrolled.

How the Plans Work

HMO Plan

Your HMO plan must authorize all of your mental health and substance abuse services to be eligible for coverage. In addition, out-of-network services are not covered under any of the HMO plans. Below is a brief look at the coverage provided by the HMO plans. Contact your HMO plan for more details.

Mental Health and Substance Abuse Coverage for HMO Plan Participants

BENEFITS	IN-NETWORK ONLY PER PLAN YEAR, PLAN PAYS:
Inpatient Care, including residential crisis services	100% for up to 365 days
Outpatient Care	◆ HMO-approved outpatient visits 1-5: 80% ◆ HMO-approved outpatient visits 6-30: 65% ◆ HMO-approved outpatient visits 31+: 50%

PPO and POS Plans

Your mental health and substance abuse benefits are provided by APS Healthcare Bethesda, Inc. The following types of services are covered under this plan:

- Inpatient facility and professional services;
- Partial hospitalization;
- Intensive Outpatient Program; and
- Outpatient facility and professional services.

To get the most from your benefits, you should contact APS before receiving any services. If you do not contact APS:

- Your benefits will be reduced by 50% for outpatient services; and
- If inpatient services are not preauthorized by APS, there will be no coverage.

You will receive the maximum benefits if you receive care from a provider that has been preauthorized by the APS Help Line. The chart on the following page outlines your benefit coverage under APS.

Did you know...

You cannot obtain mental health and substance abuse benefits through the State benefits program if you are not enrolled in a State medical plan.

Mental Health and Substance Abuse Coverage for PPO and POS Plan Participants

TYPE OF BEHAVIORAL HEALTH SERVICE	IN-NETWORK CARE (PREAUTHORIZED) PLAN PAYS	IN-NETWORK CARE (NON-PREAUTHORIZED) PLAN PAYS	OUT-OF-NETWORK CARE (PREAUTHORIZED) PLAN PAYS	OUT-OF-NETWORK CARE (NON-PREAUTHORIZED) PLAN PAYS
Inpatient Facility and Professional Services	100% of negotiated fee maximums	Not covered	80% of negotiated fee maximums	Not covered
Partial Hospitalization Services and Residential Crisis Services	100% of negotiated fee maximums	Not covered	80% of negotiated fee maximums	Not covered
Outpatient Facility	80% (first 5 visits) of negotiated fee maximum 65% (next 25 visits) of negotiated fee maximum 50% (further visits) of negotiated fee maximum	40% (first 5 visits) of negotiated fee maximum 32.5% (next 25 visits) of negotiated fee maximum 25% (further visits) of negotiated fee maximum	40% (first 5 visits) of negotiated fee maximum 32.5% (next 25 visits) of negotiated fee maximum 25% (further visits) of negotiated fee maximum	20% (first 5 visits) of negotiated fee maximum 16.25% (next 25 visits) of negotiated fee maximum 12.5% (further visits) of negotiated fee maximum
	No limit on the number of medically necessary visits per plan year; benefit reduction if authorization is not obtained; no limit on out-of-pocket expenses			
Office and Professional Services (excluding Intensive Outpatient Services)	80% (first 5 visits) of negotiated fee maximum 65% (next 25 visits) of negotiated fee maximum 50% (further visits) of negotiated fee maximum	40% (first 5 visits) of negotiated fee maximum 32.5% (next 25 visits) of negotiated fee maximum 25% (further visits) of negotiated fee maximum	40% (first 5 visits) of negotiated fee maximum 32.5% (next 25 visits) of negotiated fee maximum 25% (further visits) of negotiated fee maximum	20% (first 5 visits) of negotiated fee maximum 16.25% (next 25 visits) of negotiated fee maximum 12.5% (further visits) of negotiated fee maximum
	No limit on the number of medically necessary visits per plan year; benefit reduction if authorization is not obtained; no limit on out-of-pocket expenses			
The State will NOT pay for facility charges for outpatient services provided by hospital-based providers.				
Intensive Outpatient Services	80% (first 5 visits) of negotiated fee maximum 65% (next 25 visits) of negotiated fee maximum 50% (further visits) of negotiated fee maximum	Not covered	40% (first 5 visits) of negotiated fee maximum 32.5% (next 25 visits) of negotiated fee maximum 25% (further visits) of negotiated fee maximum	Not covered
	No limit on the number of medically necessary visits per plan year; benefit reduction if authorization is not obtained; no limit on out-of-pocket expenses			
Outpatient Medication Management Services	100% of negotiated fee maximums after a $20 co-pay is met	50% of negotiated fee maximums after a $20 co-pay is met	50% of negotiated fee maximums after a $20 co-pay is met	25% of negotiated fee maximums after a $20 co-pay is met
	No limit on the number of medically necessary visits per year; benefit reduction if authorization is not obtained; no limit on out-of-pocket expenses			
Outpatient Lab Services	Refer to medical plan for coverage level	Refer to medical plan for coverage level	Refer to medical plan for coverage level	Refer to medical plan for coverage level
Non-Medicare Coordination	As a secondary payer, your non-Medicare Coordination of Benefits (COB) will be based on the coinsurance in effect on the secondary payer plan and adjudicated based on the allowed amount of the secondary payer plan.		As a secondary payer, your non-Medicare COB will be based on the coinsurance in effect on the secondary payer plan and adjudicated based on the allowed amount of the secondary payer plan.	
Medicare Coordination	1. When Medicare is primary and your State coverage is secondary, APS will pay benefits based upon the higher of the two allowed amounts for services. 2. When Medicare is primary, preauthorization is required for inpatient services. 3. Preauthorization is not required for outpatient services when Medicare covers the service as primary. When Medicare is primary, the State's outpatient coinsurance amounts are applied.			
Claims will only be paid if filed within 365 days of the service.				

Notes about Your Mental Health and Substance Abuse Coverage

- Out-of-Network Expenses – A coinsurance expense during any one inpatient stay is limited to $1,500 per member. You may be liable for any expenses incurred beyond allowed amounts.
- Inpatient Care – There is no limit to medically necessary and treatable preauthorized inpatient days. There is a 60-day limit per plan year for partial hospitalization.
- Intensive Outpatient Services (IOP) – IOP services require preauthorization, regardless of whether in- or out-of-network.
- Outpatient Care – There is no limit on the number of medically necessary/treatable visits per year. Benefits will be reduced if preauthorization is not obtained. There is no limit on out-of-pocket expenses.

Eligible mental health and substance abuse services are covered at the same level. Substance abuse detoxification and rehabilitation services are covered under inpatient, partial hospitalization, or outpatient services when medically necessary. See the benefit chart on page 23 for how the plan will pay benefits.

If you experience a non-life threatening emergency or crisis, you will need to contact the APS Help Line at 1-877-239-1458 for immediate assistance. If you experience a life-threatening emergency, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify your care. APS team members are available 24 hours a day, seven days a week, 365 days a year.

Claims Processing for In-Network Services

If you receive preauthorized services from an in-network provider, you do not have to file any claims. If services are not preauthorized, you may have to file a claim with an itemized bill to APS for reimbursement. Please be aware that providers may include on the bill both medical and mental health services. Medical service charges must be submitted to your medical plan, and mental health charges must be submitted to APS. Please call APS for more information on filing claims.

Claims Processing for Out-of-Network Services

Your provider may ask you to pay the bill at the time of service. You must pay the provider and submit a claim form and an itemized bill to APS for reimbursement. The itemized bill should be on the provider's letterhead/stationery and include:

- Diagnosis and type of treatment rendered (including CPT code);
- Charges for the services performed;
- Date of service; and
- Patient's name and date of birth and employee's or retiree's Social Security number.

After you have completed the claim form and attached the itemized bill, mail the information directly to:

APS Healthcare Bethesda, Inc.
SOM Claims
P.O. Box 1440
Rockville, MD 20849-1440

APS will send the payment for covered services directly to the subscriber's address on file with the Employee Benefits Division. You will receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill; it is documentation of the action APS has taken on your claim.

For More Information

If you have questions about the Mental Health/Substance Abuse Plan, call APS at 1-877-239-1458 or visit www.APSHelpLink.com. You may also contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283).

Prescription Drug Benefits

The State's Prescripton Drug Plan is administered by a Pharmacy Benefits Manager, called a "PBM." The PBM can provide you with additional plan information, the location of participating pharmacies, the identification of preferred drugs, the amount of co-payment for your prescriptions, and other plan informaiton. Please see page 27 for information on how to contact the PBM. Please note that the PBM is subject to change at any time.

If you or your covered dependents are eligible for Medicare, you may have additional options for prescription drug coverage through the Medicare prescription drug plans that became available January 1, 2006. Please see the Notice of Creditable Coverage on page 50 for more information.

How the Plan Works

What You Will Pay at Retail Pharmacies

When you have a prescription filled, your co-pay is based on the type of drug you purchase and the quantity. The PBM maintains a preferred list of drugs. As shown in the chart below, you will pay less if you fill your prescription with a generic or preferred brand-name drug.

If a drug costs less than the co-pay, you will pay the actual cost of the drug. If you purchase a brand-name drug when a generic drug is available, you will pay the generic drug co-pay plus the difference in cost between the generic drug and brand-name drug.

Type of Drug	Prescriptions for 1-45 Days (1 co-pay)	Prescriptions for 46-90 Days (2 co-pays)
Generic drug	$5	$10
Preferred brand-name drug	$15	$30
Non-preferred brand-name drug	$25	$50

What You Will Pay Through the Voluntary Mail Order Program

You may also purchase prescription drugs through the PBM's Voluntary Mail Order Program. Effective July 1, 2006, if you use the Voluntary Mail Order Program, the highest standard co-payment is $20.

Beginning July 1, 2006, the co-payments under the Voluntary Mail Order Program will be:

Type of Drug	Prescriptions for 1-45 Days (1 co-pay)	Prescriptions for 46-90 Days (2 co-pays)
Generic drug	$5	$10
Preferred brand-name drug	$15	$20
Non-preferred brand-name drug	$20	$20

Please see page 27 for further information on the Voluntary Mail Order Program participation.

Out-of-Pocket Co-Pay Maximum

The Prescription Drug plan has an out-of-pocket annual co-pay maximum of $700. This means that when the total amount of co-pays you and your covered dependents pay during the plan year reaches $700, you and your covered dependents will not pay any more co-pays for eligible prescriptions for the remainder of the plan year (through June 30, 2007).

If you choose to purchase a brand-name drug when a generic drug is available, the amount of the generic co-pay will be counted toward your $700 annual co-pay maximum, but the difference between the generic and brand-name drugs will not.

If you and your spouse are both active employees and/or retirees, and you each enroll in separate individual Prescription Drug coverage, your prescription co-pays will not be combined for the purpose of meeting the $700 annual co-pay maximum. The $700 annual co-pay maximum will apply to each enrollment separately.

Preferred Brand-Name Drugs

Preferred brand-name drugs are those medications that the PBM has on its preferred drug list. This list may be different from the list in effect during the last plan year.

The PBM physicians and pharmacists evaluate the medications approved by the Food and Drug Administration (FDA). Each drug is reviewed for safety, side effects, efficacy (how well the drug works), ease of dosage, and cost. The drugs that are judged the best overall are selected as preferred brand-name drugs. You pay less if you choose preferred brand-name drugs. Preferred drugs are reviewed quarterly and are subject to change.

To get a copy of the preferred drug list, call the PBM or visit the State website at www.dbm.maryland.gov and click on Employee Services, then Health Benefits.

Voluntary Specialty Pharmacies for Highly Specialized Drugs

Many new drugs that are now being approved by the FDA are for chronic or serious diseases and are highly specialized. Your local pharmacy may not carry these drugs, called "specialty" drugs. These drugs include some anti-cancer medication, growth hormones, infertility drugs, and drugs for multiple sclerosis. The PBM offers a voluntary specialty pharmacy that helps members who need these specialty drugs. The specialty pharmacy has nurses, pharmacists, and other health care professionals who can help you obtain specialty drugs, including delivery of these drugs to your home. They can also help you with health educational materials, monitoring, and other health assistance.

Prior Authorization Drugs

Some drugs require "prior authorization" from the PBM before they can be covered under the Prescription Drug plan. Prior authorization drugs are medications that have serious or toxic side effects, or are at high risk of misuse or abuse. Prior authorization drugs include, but are not limited to:

- Retin-A growth hormones;
- Lamisil;
- Desoxyn;
- Dexedrine; and
- Adderall.

When you go to the pharmacy to obtain a drug that requires prior authorization, the pharmacist will receive an electronic message from the PBM that says your drug cannot be filled until you receive prior authorization. You will be given a toll-free number for the PBM's Prior Authorization Unit. Give this number to your physician to call. The Prior Authorization Unit physicians and pharmacists will discuss your case with your physician to determine if you meet the medical criteria for coverage.

If you are approved, you and your doctor's office will be notified. Once you are notified of approval, you can go to any participating pharmacy, since your approval will be noted on all participating pharmacies' computer systems by plan name.

If you are not approved for coverage, you may still purchase these drugs, but you will pay the entire cost. This amount will not count toward the $700 annual co-pay maximum. Drugs requiring prior authorization are subject to change at any time.

Drugs with Quantity Limits

Some drugs have limits on the quantities that will be covered under the State Prescription Drug plan. Drugs may have these limits due to warnings from the Food and Drug Administration (FDA), serious or toxic effects, or a high potential for misuse or abuse. Some drugs with quantity limits include, but are not limited to:

- Viagra;
- Proton pump inhibitors;
- Sedatives;
- Hypnotics (e.g., sleeping pills); and
- Nasal inhalers.

When you go to the pharmacy for a prescription drug with a quantity limitation, your co-pay will only cover the quantity allowed by the plan. You may still purchase the additional quantities, but you will pay the full cost. The cost of the additional quantities will not count toward your $700 annual co-pay maximum.

If you or your doctor wish to appeal the quantity limitation, your physician must call the PBM Prior Authorization Unit for approval.

The list of quantity limitation drugs is subject to change at any time.

Step Therapy

Step therapy is a process for finding the best treatment while ensuring you are receiving the most appropriate drug therapy and helping to reduce your pharmacy costs.

The first step in the step therapy process is usually a treatment that is known to be safe and effective for most people, called first-line therapy. The next step is second-line therapy. First- and second-line drugs are selected after careful review of medical literature, manufacturer product information, and consultation with medical professionals.

These steps follow the most current and appropriate drug therapy recommendations.

The PBM's computer systems will review your records for step therapy medications when you go to the pharmacy to fill a prescription. If your prescription is for a step therapy medication, the computer will search your prescription records for use of a first-line alternative.

If one is not found, the step therapy medication will not be covered. You will be required to obtain a new prescription from your physician for one of the first-line alternatives, to receive benefits coverage.

Beginning July 1, 2006, the prescription drug Celebrex is a mandatory step therapy drug. Before first-time coverage for Celebrex is provided, you may need to try other first- and second-line medications. Your physician will need to submit medical documentation to the PBM Prior Authorization Unit for Celebrex to be covered for first-time treatment.

Voluntary Mail Order

The PBM offers a voluntary mail order program that enables you to have long-term medications (for conditions such as high blood pressure, high cholesterol, or diabetes) delivered to your home. You may have your medications refilled online or by phone.

Call the PBM at their toll-free number to find out more information about voluntary mail order. You may obtain prescriptions for up to a 90-day supply with two co-pays, with the standard co-payment no higher than $20. Please see page 25 for more information on the standard co-payment you will pay.

Drug Exclusions

Some drugs and medications are excluded from coverage, including, but not limited to:

- Weight-loss drugs;
- Vitamins and minerals (except for prescription pre-natal vitamins); and
- Drugs that are labeled by the FDA as "less than effective."

Refer to the PBM's website for a full list of excluded drugs.

Current PBM

The current PBM for the State Prescription Drug Plan is Caremark. Caremark's toll-free Member Services Center telephone number is 1-800-345-9384. Caremark's website for State members is https://maryland.advancerx.com. The PBM is subject to change at any time.

For More Information

If you have any questions, please call Caremark at 1-800-345-9384. The Membership Service Center representative can answer your questions about participating pharmacies, co-pays, preferred drugs, prior authorization drugs, quantity limitation drugs, etc. You may also visit the State's website at www.dbm.maryland.gov for information on the State plan and to compare the cost of drugs.

Dental Benefits

Your Choices

Dental coverage is available to all individuals who are eligible for State health benefits. You have three dental plans from which to choose:

- **Two Dental Health Maintenance Organization (DHMO) plans:**
  - Dental Benefit Providers; or
  - United Concordia;
- **One Dental Preferred Provider Organization (DPPO) plan:**
  - United Concordia.

You must be enrolled in one of the three dental plans if you want to have dental benefits.

How the Plans Work

The DHMO Plans

When you enroll, you must select a Primary Dental Office (PDO) from your selected Dental HMO's network of participating dentists. Your PDO will provide, or coordinate, all of your dental care services, including referrals to specialists.

- The Dental Benefit Providers DHMO allows you to select up to two different PDOs per family.
- The United Concordia DHMO allows you to select a different PDO for each member of your family.

You may change your primary provider site selection throughout the plan year by contacting your dental plan. The DHMO Plans will only pay benefits for in-network coverage, unless it is an out-of-area emergency (see below).

Please note: The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. If your dentist discontinues participation in the plan, is terminated from the plan, or closes their practice to new patients, you will not be allowed to change your plan or withdraw from the plan until the next Open Enrollment period. If this happens, contact your dental plan to select another provider.

Predetermination of Benefits

There is no requirement for you or your dentist to seek predetermination of benefits before treatment starts. However, you are encouraged to do so for major dental procedures so that you and your dentist will know exactly what will be covered and what you will need to pay out-of-pocket.

What's Covered – DHMO Plans

Feature	Benefit Coverage (In-Network Services Only)
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services, including exams, X-rays, cleanings, sealants, fluoride treatments, treatment of pain, other preventive care services	You pay $0
Restorative services, including restoration of teeth, space maintainers, extraction of teeth, endodontic (root canal) services, periodontal services (including surgical and non-surgical services), oral surgery	You pay according to the DHMO Benefit Schedule*
Major Restorative services, including crowns, inlays, onlays, bridges, dentures, denture repair	You pay according to the DHMO Benefit Schedule*
Orthodontia (for adults and children), including evaluation and consultation, orthodontic treatment, orthodontic retention	You pay according to the DHMO Benefit Schedule*

*** Review the Schedule of Benefits for each plan for the fee schedule amounts associated with each type of dental service, as they may differ between plans. Services not listed on the Schedule of Benefits are not covered. The Schedules of Benefits for the DHMO plans are located on the State website at www.dbm.maryland.gov, and on the provider websites.**

Out-of-Area Emergencies

Your DHMO will pay a maximum of $50, subject to your fee schedule, for emergency dental services when you are traveling out of the area (more than 50 miles from your dentist's office). To receive payment for out-of-area emergency care, you must submit a bill itemizing the charges and services performed, and forward the claim to your Dental HMO for processing.

DHMO Network

If you live in an area that does not have a DHMO network of dentists, please contact the DHMO to determine other options. In addition, you may request that the plan evaluate the dentist of your choice for inclusion in the network. However, there is no guarantee that a provider that you request will choose to participate in the plan network. In a DHMO plan, you can only receive coverage for services from a DHMO plan provider.

The DPPO Plan

The DPPO plan is available through United Concordia. Under this Plan, you do not have to select a PDO. You may choose to receive services from any dentist of your choice whenever you receive services. Benefit coverage amounts are higher if you choose an in-network PPO dentist for services. If you use an out-of-network dentist, you will need to file a claim form for reimbursement. No referrals are needed for specialty care. Orthodontia services are only covered for eligible children age 23 and younger.

What's Covered – DPPO Plan

Feature	Benefit Coverage (In-Network and Out-of-Network Services)
Annual deductible	$50 per individual; $150 per family Only applies to Class II and Class III services
Annual maximum	$1,500 per participant
Class I: Preventive services, initial periodic and emergency examinations, radiographs, prophylaxis (adult and child), fluoride treatments, sealants, emergency palliative treatment, space maintainers	Plan pays 100% of allowed amount
Class II: Basic Restorative services, including fillings, inlays, endodontic services, periodontal services, oral surgery services, general anesthesia, prosthodontic maintenance, relines and repairs to bridges, and dentures	Plan pays 70% of allowed amount, after deductible
Class III: Major services, including crowns and bridges, dentures (complete and partial), fixed prosthetics	Plan pays 50% of allowed amount, after deductible
Class IV: Orthodontia (for eligible child only, age 23 or younger)	Plan pays 50% of allowed amount, up to $2,000 lifetime maximum

For More Information

If you have questions about the dental plans, refer to the inside cover of this booklet for phone numbers and websites. You may also contact the Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283).

Flexible Spending Accounts (active employees only)

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck, on a pre-tax basis, to pay for a wide variety of common health care and dependent day care expenses for you and your eligible dependents.

Even with an insurance plan, health care expenses can add up. From deductibles and co-pays to items not covered by insurance, the rising cost of health care can put a strain on your budget. And families paying for dependent day care, whether for children or for elders, know how expensive that can be as well.

FSAs provide tax savings to help you offset the rising cost of health care and dependent day care expenses. You may want to discuss your personal situation with a tax advisor before deciding how to make an FSA work for you. The State FSAs are administered by SHPS, Inc.

Your Choices

Two types of accounts are available:

- **Health Care Account** (contribute between $120 and $3,000 a year) – for eligible health care expenses not reimbursed by any medical, dental, or prescription plan you or your dependents may have
- **Dependent Day Care Account** (contribute between $120 and $5,000 a year, or up to $2,500 a year if married and filing separately) – for eligible dependent day care expenses incurred so you and your spouse, if married, can work or look for work, or your spouse can attend school full-time

Tax Savings with an FSA

An FSA lets you set money aside for eligible expenses before your employer deducts taxes from your paycheck. This means the amount of income your taxes are based on will be lower and, as a result, the amount you owe in taxes will also be lower.

Let's assume "Sue" earns $35,000 a year and has $1,500 in eligible expenses. The example below illustrates what she will pay with an FSA and without an FSA.

	With FSA	Without FSA
Annual pay	$35,000	$35,000
Pre-tax contribution to FSA	– $1,500	– $0
Taxable income	= $33,500	= $35,000
Federal income and Social Security taxes	– $7,107	– $7,597
After-tax dollars spent on eligible expenses	– $0	– $1,500
Spendable income	= $26,393	= $25,903
Tax savings with your FSA	$26,393 – $25,903 = **$490**	

Sample tax savings for a single taxpayer with no dependents; actual savings will vary based on your individual tax situation; please consult a tax professional for more information

As you can see, Sue's taxable income goes down to $33,500, which saves $490 in taxes. In other words, Sue saved $490 in taxes by enrolling in her FSA. This tax savings is nearly 33% of the expenses she would have had to pay anyway.

How the Plans Work

Opening and using an FSA is easy.

Step 1. Determine how much money you need to set aside on an annual basis. The mySHPS calculator at www.myshps.com can help you plan your account contribution.

Step 2. That amount is deducted from your pay on a pre-tax basis in equal amounts, depending on your frequency of pay, throughout the year. For example, if you're paid 24 times a year and you elect to contribute $780, you would have $32.50 deducted from each paycheck and credited to your FSA.

Step 3. When you have eligible expenses, pay them out of your pocket.

Step 4. Submit a request for reimbursement. You should include appropriate documentation to support your reimbursement, such as an itemized receipt or an explanation of benefits from your insurance company.

Step 5. SHPS will promptly process your reimbursement requests, often within a few working days. (If the amount of your request is less than the required minimum reimbursement amount of $20, SHPS will hold payment until you file additional requests.)

You may be reimbursed from the Health Care Account at any time throughout the year for expenses up to the annual amount you elected to contribute. However, you may only be reimbursed from the Dependent Day Care Account up to your current balance. If you file a reimbursement request for more than your current balance, it will be held until additional contributions have been added to your account.

Plan carefully when deciding how much to contribute.

Because of the tax benefits of the FSAs, the IRS places strict guidelines on them. One of the most important is the "Use-It-or-Lose-It" rule. If you have unused dollars in your account at the end of the year, you cannot roll them over to the next plan year, and they cannot be paid out to you. So plan carefully when deciding how much you want to contribute.

Grace Period for Health Care Account

You now have an extra 2 ½ months at the end of the plan year to incur eligible health care expenses before you must forfeit any remaining funds. This means you now have until September 15 of each year to spend funds from the plan year ending on June 30. (Dependent Day Care Account expenses must still be incurred by June 30.) All claims must still be postmarked by October 15 in order to be considered.

Health Care Account

Who is Covered

You can use the Health Care Account to pay eligible health care expenses for yourself, your spouse, and anyone you claim as a dependent on your federal income tax return.

What Expenses are Covered

The Health Care Account is used for tax-deductible health care expenses not paid by insurance. All eligible expenses are based on your employer's benefit plan design and IRS regulations. Please contact SHPS for information on whether an expense is eligible, or visit their website at www.shps.com.

Dependent Day Care Account

Who is Covered

You can use the Dependent Day Care Account to pay eligible expenses for the care of:

- Your dependent children under age 13; and
- A person of any age whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for himself or herself.

What is Covered

The Dependent Day Care Account is used for dependent day care expenses that allow you (or you and your spouse, if married) to work or look for work, or that allow your spouse to attend school full-time. The care may be provided inside or outside your home.

Grace Period Example

Suppose you contributed $1,250 to your Health Care Account for the 2005-2006 plan year, and by June 30, 2006, you have spent $1,000 in FSA-eligible health care expenses. Under the previous rule, you would lose the $250 remaining in your account on June 30, 2006. But, under the new grace period rules, you'll have until September 15, 2006 to incur an additional $250 in eligible expenses to be submitted with a postmark of no later than October 15, 2006.

Step 1. You submit a reimbursement request.

To be reimbursed for eligible expenses, you complete and sign a simple form and include an explanation of benefits (EOB) or detailed receipt as proof of services rendered. The form is available at www.myshps.com, or you can call 1-877-358-4276 to request a form. Fax your form to 1-866-643-2219 or mail it to:

SHPS FSA Administration
P.O. Box 34700
Louisville, KY 40232

Reimbursement forms are accepted at any time for expenses incurred during the current plan year. You also have a 2½-month grace period for health care expenses following the end of the plan year to submit expenses.

Step 2. SHPS sends your money.

SHPS processes and pays reimbursement requests daily for prompt service. You have the option to receive payment by check or Electronic Funds Transfer (EFT), which deposits your reimbursement directly into your designated checking or savings account. On average, your request will be processed within 5 days of receipt and you will receive your money within 10 days (sooner if you use direct deposit).

If the reimbursement amount is less than the required minimum payment amount for your plan, payment will be held until your reimbursement reaches that amount. However, you may only be reimbursed from the Dependent Day Care Account up to your current balance. If you file a reimbursement request for more than your current balance, it will be held until additional contributions have been added to your account.

Getting Reimbursed

When you incur eligible expenses, you want your money fast. As your FSA administrator, SHPS expedites your reimbursement with a simple process, as described next.

Confirmation of Your Claim

If you fax your claim, SHPS will confirm receipt by sending you an e-mail confirmation, provided that your e-mail address is included on the claim form.

Direct Deposit

Reimbursement checks are normally mailed to your home address, but you can avoid waiting for the check in the mail. SHPS can deposit your reimbursement funds directly into your checking or savings account through Electronic Funds Transfer (EFT). You can sign up for EFT at www.myshps.com. Simply log in to your account and click on the FSA Direct Deposit Sign-up button. You can also download an EFT application and mail your completed form.

SHPS Makes it Easy to Keep Track of Your FSA

With SHPS, you can get the information you need – either online or by phone.

Online

The SHPS online account service is called mySHPS and is available 24 hours a day, seven days a week at www.myshps.com. With mySHPS, you can:

- Determine how much you want to contribute to your FSA – and your potential tax savings – using the interactive calculator;
- Review a list of eligible expenses;
- Download reimbursement forms and general information about the FSAs;
- Check your current account balance and find out if a reimbursement has been processed (Just enter your personal identification number and password on the secure participant login screen.); and
- Submit questions or feedback to SHPS.

Please note: SHPS uses 128-bit encryption to protect the privacy of your information.

By Phone

You can also obtain your account balance and the status of your last claim using the automated telephone service. Simply call the SHPS Customer Service Center at 1-877-358-4276. You'll be asked to enter your personal identification number.

If you need more information, SHPS customer service representatives are available between 8:00 a.m. and 8:00 p.m. (Eastern Time), Monday through Friday.

For More Information

If you have questions about the FSAs, call SHPS at 1-877-358-4276 or visit www.shps.com.

For a comprehensive list of eligible health and dependent day care expenses, visit www.myshps.com.

Health Care Account – Eligible Expenses

Sample eligible expenses include:

- Co-pays, coinsurance, and deductibles (but not premiums);
- Acupuncture;
- Birth control pills;
- Childbirth classes;
- Chiropractic visits;
- Dental care;
- Diabetic supplies;
- Eye exams, glasses, and contacts;
- Hearing aids;
- Laser eye surgery;
- Orthodontia;
- Over-the-counter drugs and medical supplies;*
- Physical therapy;
- Prescription drugs;
- Psychotherapy;
- Smoking cessation programs;
- Speech therapy;
- Sterilization surgery; and
- Well-baby and well-child care.

* Below is a sample list of over-the-counter (OTC) drugs that are primarily used for medical care. Receipts must state the name of the medicine or drug, the date, and the amount paid. You will not require a statement from a medical practitioner.
  - Allergy and asthma medicines, nasal sinus sprays;
  - Pain relievers – topical creams and oral medicines;
  - Cough drops, throat lozenges, cough syrup, cold medicines, and flu relief;
  - Nicotine gum or patches for stop-smoking purposes;
  - Antibiotic cream, cortisone cream, first aid spray, calamine lotion, bug bite medication;
  - Eye drops, allergy eye drops, contact lens cleaning solution; and
  - Medical supplies.

Dual-Purpose Examples:

This is a sample list of OTC drugs that may have both a medical purpose and a general health purpose. In order for the OTC expense to be reimbursed, you will need to obtain a medical practitioner's note stating that you have a specific medical condition and that the OTC drug is recommended to treat the condition.

- Weight-loss drugs to treat a diagnosed disease (e.g., obesity);
- Feminine hygiene products (e.g., for use after surgery or child birth);
- Sunscreen (e.g., persons diagnosed with skin cancer);
- Joint supplements for diagnosed joint condition (e.g., arthritis);
- OTC hormone therapy;
- Dietary supplements to treat a specific medical condition (e.g., Vitamin B prescribed for treatment of scurvy);
- Prenatal vitamins;
- Supplements such as iron, calcium, etc.; and
- Fiber supplements to treat a specific medical condition for a limited time.

Items such as vitamins, herbal and dietary supplements, cosmetic treatments, or items that are for maintaining general good health are not eligible expenses.

You are still required to provide documentation in the form of a cash register receipt that must clearly identify the name of the purchased item.

Health Care Account – What is Not Covered

Sample ineligible expenses include:

- Cosmetic procedures (unless required to restore appearance or function due to disease or illness);
- Expenses you claim on your income tax return;
- Expenses reimbursed by other sources, such as insurance plans;
- Fitness programs (unless medically necessary);
- Hair transplants;
- Illegal treatments, operations, or drugs;
- Benefit insurance premiums, including COBRA;
- Prescription drug discount fees; and
- Weight loss programs for general well-being.

This is a sample list of OTC items that may **not be reimbursed under any circumstances.** These items are likely to be primarily for general health.

- Toothpaste, toothbrushes, dental floss;
- Make-up, lipstick, eye cream;
- Face cream, moisturizers;
- Perfume, body sprays, deodorants;
- Shampoos and soaps;
- Acne treatments (rarely reimbursable);
- Foot-care products like corn pads;
- Hair loss treatments; and
- Dietary supplements and replacements (vitamins).

Dependent Day Care Account – Eligible Expenses

Sample eligible expenses include:

- Care of a child under age 13 at a day camp, nursery school, or by a private sitter for a child that lives in your home at least eight hours a day;
- Before- and after-school care (must be kept separate from tuition expenses);
- Care of an incapacitated adult who lives with you at least eight hours a day; and
- Expenses for a housekeeper whose duties include caring for an eligible dependent.

Dependent Day Care Account – What is Not Covered

Eligible dependent day care services cannot be provided by a person you are claiming as your dependent. You will need the Social Security or tax identification number of the person or facility that provides the care.

Sample ineligible expenses include:

- Education and tuition fees;
- Late payment fees;
- Overnight camps (in general);
- Sports lessons, field trips, clothing; and
- Transportation to and from a dependent day care provider.

Term Life Insurance

Life Insurance coverage provides your beneficiary with a lump sum payment in the event of your death (or you, in the event of your dependent's death). The Policy number for term life insurance through The Standard Insurance Company is #642220.

No Duplication of Benefits or Enrollment

You cannot have duplicate Life Insurance coverage under the State plan. If you and your spouse are both State employees and/or retirees, and you cover yourself for Life Insurance, you cannot be covered as a dependent of your spouse. Also, children of State employees and retirees cannot have duplicate coverage under both parents. The Standard will only pay benefits for one policy.

Beneficiaries

The Standard requires a valid beneficiary designation on file. If you do not name a beneficiary, or if you are not survived by one, benefits will be distributed according to the order detailed in The Standard's certificate of group coverage, as follows.

Benefits will be paid in equal shares to the first surviving class of the following:

- Your spouse;
- Your children;
- Your parents;
- Your siblings; or
- Your estate.

Beneficiary designation forms are available from your Agency Benefits Coordinator or from The Standard's website: **www.standard.com/mybenefits/maryland**.

Life Insurance for Active Employees

Your Choices

Coverage for Yourself

You may choose coverage in $10,000 increments up to a maximum of $300,000. You may choose up to $50,000 guaranteed coverage without completing a medical history statement. If you select coverage greater than $50,000 for yourself, you must complete and submit the medical history statement to be reviewed by The Standard.

Coverage for Your Dependents

You may choose to purchase coverage for your dependents who are eligible for health benefits with the State in $5,000 increments up to half of your coverage amount (up to a maximum of $150,000). You may choose up to $25,000 guaranteed coverage for eligible dependents without a medical history statement. If you select coverage greater than $25,000 for a dependent, a medical history statement for each dependent whose requested coverage exceeds $25,000 must be completed and reviewed by The Standard.

Please Note:

- Dependent eligibility requirements for Term Life Insurance are the same as the requirements for all other plans.
- Dependents with Life Insurance who become ineligible may contact the plan for information to convert to an individual whole life insurance policy within 31 days. Please contact The Standard's Continued Benefits Department at 1-800-378-4668 ext. 6785.
- Medical history statements are available from your Agency Benefits Coordinator or from The Standard's website: **www.standard.com/mybenefits/maryland**.

How the Plan Works During Active Employment

New Enrollment

For new enrollment in The Standard Term Life Insurance plan offered through the State to begin, you must be actively at work, employed by the State of Maryland, and performing services for compensation on regularly scheduled working days. Regularly scheduled working days do not include holidays, non-work days, vacations, or other scheduled leaves. Actively at work means that you have worked at least 20 hours over the last seven consecutive calendar days at either your usual place of employment or away from your usual place of employment at the agency's convenience, and that you are not currently on sick leave or other type of scheduled leave.

Changing Coverage and When Coverage is Effective

If you are currently enrolled in the plan, you may continue at your current coverage level each plan year without medical review. If you want to increase your coverage to more than $50,000 during Open Enrollment, regardless of your current coverage amount, you must file a medical history statement with the plan. Please note that your increased coverage amount will become effective on the later of:

- The first day of the new plan year;
- The date The Standard approves your medical review; or
- The date you become actively at work.

If your request for increased coverage is denied, your coverage will remain at your previous amount.

Accelerated Benefit

An Accelerated Benefit is available in the event of a terminal illness. An insured employee (or insured spouse) has the option for early access up to 50% of the face amount of the insurance coverage, if the insured person is medically certified by The Standard to be terminally ill with less than six months to live, and has at least $10,000 in coverage.

Waiver of Premium During Total Disability

If you become totally disabled before you reach age 60 and are enrolled in the Term Life Insurance plan as an active State employee on your date of disability, you may be entitled to a waiver of premium after nine months of total disability. To apply for a waiver of premium, you must submit a waiver of premium application to The Standard on the ninth month of your total disability. If approved, your premiums will be waived. Once you are approved for a waiver of premium, Life Insurance coverage for you and your covered dependents will be directly through The Standard. The coverage will end when you reach age 65 or when you are no longer disabled, whichever comes first. When your waiver of premium ends you will be eligible to convert your coverage to an individual whole life insurance policy by contacting The Standard's Continued Benefits Department.

Previous Waiver of Premium With MetLife

If you already have a waiver of premium with Metropolitan Life Insurance Company (MetLife), the former life insurance plan carrier, coverage for you and your dependents is directly through MetLife and not with the State. Your coverage will end when you reach age 65 or are no longer disabled, whichever comes first. You may then convert to an individual policy with MetLife. Your coverage does not transfer over to The Standard. Please contact MetLife at 1-888-842-2757 for more information.

Conversion and Portability of Coverage

If you leave employment with the State, you may continue your Term Life Insurance coverage on an individual basis. Two options are available:

- Portability – an individual term life insurance policy; or
- Conversion – an individual whole life insurance policy.

Please contact The Standard Account Service Manager at 1-888-246-9002 or the Continued Benefits Department at 1-800-378-4668 ext. 6785 for eligibility requirements and information about each option.

Please note: You only have 31 days from your termination date to select one of these options.

Life Insurance Upon Retirement

Your Choices

Coverage for Yourself

As of January 1, 1995, State retirees who retire directly from State service may:

- Continue Life Insurance at the same coverage level, subject to the age-related reduction schedule;
- Reduce Life Insurance coverage to a minimum of $10,000, also subject to the age-related reduction;
- Cancel Life Insurance coverage; or
- Convert to an individual policy.

You cannot increase your Life Insurance coverage or add new dependents to your Life Insurance coverage upon retirement or at any time after retirement. If you choose to reduce or cancel Life Insurance coverage, you will not be permitted to increase coverage or re-enroll in the State Life Insurance plan in the future.

There can be no break in Life Insurance coverage between active employment and retirement.

Coverage for Your Dependents

As a retiree, you may also choose to continue, reduce, or cancel your dependent Life Insurance coverage for any dependents that were covered under the Life Insurance plan while you were an active employee.

Your dependent's Life Insurance cannot be more than half of your Life Insurance coverage amount.

How the Plan Works During Retirement

Automatic Reduction of Benefits for You and Your Dependents

Life Insurance benefits for you and your dependents will reduce automatically based on your age, according to the chart below. New retirees who are at least 65 at the time of retirement, and their covered dependents, will have an immediate reduction of benefits at the time of their retirement. The premiums are based on the reduced level of coverage and the current age bracket of each covered member. The reduction schedule is as follows:

At Age...	Benefits Reduce To...
65	65% of your or your dependent's original amount
70	45% of your or your dependent's original amount
75	30% of your or your dependent's original amount
80	20% of your or your dependent's original amount

The benefit amount lost at the time of the reduction can be converted to an individual whole life insurance policy within 31 days of the reduction of coverage by calling The Standard's Continued Benefits Department at 1-800-378-4668 ext. 6785.

For More Information

If you have questions about coverage, conversion policies, limitations, definitions, restrictions, terminating events, or exclusions, please call The Standard service representative at 1-888-246-9002. The Standard also has a dedicated website for the State of Maryland's Group Term Life Insurance Plan. The website address is www.standard.com/mybenefits/maryland. On this website, you can find beneficiary designation and change forms, as well as medical history statements.

Accidental Death and Dismemberment Plan

The Accidental Death and Dismemberment (AD&D) Plan is available to all active employees and their dependents who are eligible for health benefits with the State. The AD&D Plan is offered through Metropolitan Life Insurance Company (MetLife). The plan provides benefits in the event of an accidental death or dismemberment. No medical review is required for enrollment in the plan. This plan will cover you for accidents that occur at work as well as accidents off the job.

Your Choices

You can choose individual or family coverage in an amount equal to:

- $100,000
- $200,000
- $300,000

If you choose family coverage, your dependents are covered for a percentage of your benefit amount, as listed below:

Dependent	Benefit
Spouse (if you have children)	55% of your principal benefit amount
Eligible dependent children (if you have a spouse)	15% of your principal benefit amount
Spouse (if no eligible dependent children)	65% of your principal benefit amount
Eligible dependent children (if no spouse)	25% of your principal benefit amount

Please note: There is a maximum benefit of $50,000 per covered dependent child.

How the Plan Works

Benefits will be paid within 365 days of the date of an accident. The plan will pay, in one sum, a certain percentage of the principal benefit amount, depending on whether there is a loss of life or some type of dismemberment. If more than one covered loss is sustained during one accident, the plan will pay all losses up to the principal sum amount.

AD&D Benefits Chart

EMPLOYEE LOSS	BENEFIT AMOUNT
Loss of life	100%
Both hands or both feet	100%
Entire sight of both eyes	100%
One hand and one foot	100%
One hand and entire sight of one eye	100%
Speech and hearing (both ears)	100%
Quadriplegia	100%
Paraplegia	75%
One hand or one foot	50%
Entire sight of one eye	50%
Speech or hearing	50%
Hemiplegia	50%
Thumb and index finger of same hand	25%

The AD&D Plan provides other benefits in the event of a covered loss. Additional benefits include:

- Exposure and disappearance;
- Waiver of premium;
- Education;
- Day care;
- Seat belt;
- Common disaster;
- Emergency evacuation; and
- Repatriation of remains.

For More Information

Please contact MetLife at 1-888-842-2757 for an AD&D Beneficiary Designation Form, as well as for information about the plan. You must complete an updated AD&D Beneficiary Designation Form for MetLife.

Long Term Care Insurance

Long Term Care (LTC) is the help or supervision provided for someone with severe cognitive impairment or the inability to perform the Activities of Daily Living, including bathing, dressing, eating, toileting, transferring, and continence. Services may be provided at home or in a facility – and care may be provided by a professional or informal caregiver, such as a friend or family member.

Effective July 1, 2006, the Long Term Care (LTC) Insurance plan is offered through The Prudential Insurance Company of America. If you are currently enrolled in the Long Term Care Insurance plan through Unum, refer to the Current Unum Plan Participant Options heading later in this section.

Why do I need LTC Insurance?

Your odds of needing Long Term Care Insurance may be greater than you think. More than 2 in 5 people over the age of 65 will require nursing home care at some time in their lives.[1] It could be the result of spinal cord injury, heart attack, stroke, or age-related illness such as Parkinson's Disease or Alzheimer's Disease.

How expensive is LTC?

It can cost over $61,000 a year for nursing home care alone.[2] When people suddenly find themselves the primary caregiver for a loved one, the responsibility could result in a huge financial and emotional burden.

Isn't care covered by other insurance?

Disability income insurance provides no benefits for the services covered by LTC insurance – while Medicaid and Medicare have significant limitations.

Why should I get coverage now?

The State has made it possible for you to buy this valuable, portable coverage at low group rates. If you are a permanent actively at work State of Maryland/Satellite Account employee who works at least 20 hours per week, and you enroll during this Open Enrollment period only, you will be enrolled in the plan without providing any medical history (called "guaranteed issue"). However, if you are on a Leave of Absence during this Open Enrollment period only, when you return to active status, you will have a one-time 60-day enrollment period in which to elect LTC coverage with guaranteed issue.

Am I too young for LTC insurance coverage?

It's never too early to purchase coverage. You may be surprised to learn that 40% of LTC insurance benefit recipients are under the age of 65.[3] And the younger you are when you first purchase Long Term Care Insurance, generally the lower your premium for the life of your plan, regardless of your age or health status in later years.

Can I get coverage for other family members, too?

You can also extend coverage to qualifying family members (such as a spouse, parent, or grandparent). To be considered for enrollment, they will need to provide evidence of good health to Prudential.

What happens to my coverage if I leave employment with the State of Maryland?

The LTC Insurance plan is portable. If you leave employment with the State, you can take your LTC Insurance coverage with you.

Are LTC premiums pre-tax deductions?

No. Under Federal guidelines, LTC premiums cannot be pre-tax deductions.

[1] **"Long Term Care Insurance: Who Really Needs It?", Journal of Financial Planning, Sept. 2004**

[2] **Prudential Financial Long Term Care Cost Survey, 2004**

[3] **Americans for Long-Term Care Security (ALTCS), "Did You Know," 2005, www.ltcweb.org/learn.html#did**

Your Choices

LTC Insurance is available to all actively at work full-time and part-time State of Maryland/Satellite Account employees, State retirees, and their family members. Unlike other plans outlined in this booklet, LTC is offered to:

- Spouses;
- Parents (in-laws included);
- Grandparents (in-laws included); and
- Children age 18 or older and their spouses.

For each individual you choose to cover, you must select one of the plans listed below.

Plan Option	Nursing Home Care & Assisted Living Facility Daily Maximum*	Home & Community-Based Care Daily Maximum*	Lifetime Maximum**
Plan 1	$85	$43	$93,075
Plan 2	$85	$43	$186,250
Plan 3	$100	$50	$109,500
Plan 4	$100	$50	$219,000
Plan 5	$150	$75	$164,250
Plan 6	$150	$75	$328,500
Plan 7	$200	$100	$219,000
Plan 8	$200	$100	$438,000

* Benefits are paid up to the daily maximum.

** All benefits paid will be deducted from the lifetime maximum.

How the Plan Works

In order to receive benefits, you must be assessed/certified by a licensed health care practitioner and be confirmed as having a chronic illness or disability.

A qualifying chronic illness or disability is one in which there is:

- A loss of the ability to perform, without substantial assistance, at least two of the Activities of Daily Living (ADLs). This loss must be expected to continue for at least 90 days. ADLs are bathing, continence, dressing, eating, toileting, and transferring; or
- A severe cognitive impairment, which requires substantial supervision to protect you from threats to your health and safety.

Benefit Waiting/Elimination Period

Before you can receive benefits, you must satisfy the 90-day benefit waiting/elimination period. This period is counted in calendar days and begins on the date you are assessed, if you are determined to be eligible for benefits. You do not need to receive formal LTC services to satisfy the waiting period, and this waiting period only needs to be satisfied once during the period you are covered by the Prudential LTC plan.

Periodic Inflation Protection

As part of the plan, you may increase your coverage on a periodic basis without submitting any additional health information (as long as you have not declined the previous two consecutive inflation offers). Inflation protection will be offered at least every three years to individuals who do not elect the optional automatic inflation protection feature.

Guaranteed Issue for Actively at Work Employees

Keep in mind, if you are a permanent actively at work State of Maryland/Satellite Account employee who works at least 20 hours per week, you can receive guaranteed issue coverage if you enroll during this Open Enrollment period. That means you do not have to provide medical history to be approved for coverage. If you plan to retire on July 1, 2006, but are actively at work during the Open Enrollment period, you are eligible to receive the guaranteed issue coverage. In addition, newly hired employees who meet the above criteria will have a 60-day enrollment period in which to elect LTC coverage with guaranteed issue. (State retirees and all family members covered by active employees or retirees must provide medical history to be approved for coverage.)

Optional Features

You may customize your plan to meet your needs and the needs of your family members by choosing either of these optional features:

- Automatic inflation protection – coverage amounts increased at least 5% per year, compounded annually
- Non-forfeiture shortened benefit period – allows you to retain access to a portion of the benefits if you stop paying premiums (after at least five years)

Keep in mind that choosing optional features will increase your premium amount.

Additional Benefits

The LTC Insurance plan through Prudential also offers these additional benefits:

- Bed reservation;
- Hospice care;
- Respite care;
- Independence support;
- Informal care;
- Caregiver training;
- Information and referral services;
- Private care management;
- Alternate plan of care;
- Death benefit;
- Cash alternative;
- International coverage benefit; and
- Marriage discount.

Exclusions

Benefits will not be payable if any of the following situations apply:

- **Work-connected conditions charge:** A charge covered by a Workers' Compensation law, occupational disease law, or similar law
- **Government plan charge:** A charge for a service or supply:
  - Furnished by or for the United States government or any other government, unless payment of the charge is required by law; or
  - To the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered*
- **Self-inflicted injury or suicide:** Charges arising from intentionally self-inflicted injury or attempted suicide, while sane or suffering from inorganic-based insanity or mental illness
- **Services and supplies outside the United States:** Charges for services or supplies outside the United States and its possessions (does not apply to the International Coverage Benefit)
- **Treatment for chronic alcoholism or chemical dependency:** Charges in connection with the treatment of chronic alcoholism or chemical dependency
- **War, felony, riot, or insurrection:** Charges for a condition due to war or any act of war while you are insured or due to the insured's participation in an act of felony, riot, or insurrection**

* This does not apply to a State plan under Medicaid or to any law or plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. When this is applied to Medicare, the benefits provided by Medicare will be deemed to include any amount that would have been payable by Medicare in the absence of a deductible or coinsurance requirement under that program.

** War means declared or undeclared war and includes resistance to armed aggression. Riot means a wild, violent, public disturbance of the peace.

For More Information

For more information, to enroll, or to download enrollment forms:

- **Visit www.prudential.com/gltc (group name: maryland; password: marylandltc); or**
- **Call 1-800-732-0416, Monday through Friday, 8:00 a.m. to 8:00 p.m., ET.**

Current Unum Plan Participant Options

If you are currently enrolled in the LTC Insurance plan with Unum, you have several options:

- **Keep your Unum Plan coverage** by paying your premiums directly to Unum. You will receive a letter from Unum about this conversion option and instructions for setting up a payment plan to continue your coverage. You must convert with Unum, or your coverage will end on June 30, 2006.
- **End your Unum Plan coverage** by not converting to an individual plan with Unum. Your Unum coverage would then end on June 30, 2006.
- **Enroll in the new Prudential LTC Insurance plan** offered through the State, with guaranteed issue during the Spring 2006 Open Enrollment for permanent State of Maryland/Satellite Account employees who work at least 20 hours per week. You will not need to complete a medical questionnaire (unless you are covering family members). All others will need to complete the Medical History & Insurability Form to be considered for LTC Insurance.
- **Have coverage through both plans**. To continue your Unum Plan coverage, you must convert to an individual Unum Plan policy and pay your premiums directly to Unum and then enroll in the new Prudential LTC Insurance plan during Open Enrollment.

If any of your family members are enrolled in the Unum plan through the State, they have the same options. Remember, for all family members, acceptance in LTC is dependent upon the medical review. Family members may want to wait for approval from Prudential before canceling a Unum LTC policy.

If you have additional questions about your Unum conversion rights, or if you have not received your conversion letter from Unum, please contact Unum at 1-800-227-4165.

There is no waiting period for hospice care, independence support, caregiver training, information and referral services, or private care management.

Beginning May 1, 2006, you can find more information about these benefits on Prudential's website at www.prudential.com/gltc (group name: maryland; password: marylandltc).

Important Notices and Information

Continuation of Coverage/COBRA

While on Leave of Absence

If you take a Leave of Absence Without Pay (LAWP) you may continue the same health benefits coverage by electing to enroll and paying the full cost of your premiums.

If you take a leave of absence pursuant to the Family Medical Leave Act (FMLA), special rules govern the continuation of your health benefits. Contact your Agency Benefits Coordinator for details.

Short-Term LAWP

If you are on short-term LAWP (two pay periods or less for employees who are paid bi-weekly; up to 28 days), and it is not FMLA leave or due to a job-related accident or injury (LAW-OJI), you must pay the full cost (both employee share and State subsidy) of all missed premiums in order to continue your benefits for the rest of the plan year. You will receive a bill from the Employee Benefits Division for your missed premiums. Deductions may resume if you return to work before the due date on the bill. However, payment for the missed premiums is still due. If you do not pay by the due date on the "no-pay" bill, your enrollment and benefits coverage will be cancelled for the balance of the plan year.

If your short term LAWP is due to a job-related accident or injury (LAW-OJI), or an approved FMLA leave, you are entitled to the full State subsidy and are responsible for the employee's share of the premium only. When you receive your bill, please contact your Agency Benefits Coordinator, who will complete a retroactive adjustment form and collect your portion of the premiums. You must make up missed premiums within the requested timeframe or your enrollment and benefits coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. Payment deadlines are strictly enforced.

Long-Term LAWP

If you are on a leave of absence without pay for more than two bi-weekly pay periods (more than 28 days), your leave is considered a long-term LAWP. If you are on an approved long-term LAWP, you may elect to continue or discontinue health insurance for the duration of the LAWP, up to a maximum of two years.

You must notify the Employee Benefits Division of your coverage election within 60 days of beginning your long-term LAWP. You cannot retroactively terminate benefits and you may be required to pay the full premium for any period of coverage during your long-term LAWP that has elapsed prior to your notification to terminate benefits during your long-term LAWP.

If you wish to continue, you must complete a COBRA/LAWP enrollment worksheet and submit it to your Agency Benefits Coordinator. This worksheet should be completed as soon as you know you will miss two pay periods or more. The worksheet will not be accepted any later than 60 days after the effective date of the LAWP.

You may continue any or all of your current health benefit plans, or you may reduce your coverage level when enrolling for LAWP benefits. However, you may not change plans until the next Open Enrollment period or within 60 days of a qualifying event, the same as an active employee.

Once enrolled in coverage while on LAWP, you are responsible for the full premium cost unless the LAWP is due to a job-related accident or injury or an approved FMLA leave. If you are entitled to the State subsidy, your Agency Benefits Coordinator must have the Agency Fiscal Officer complete the applicable section of the COBRA/LAWP enrollment worksheet. The Employee Benefits Division will bill you for the appropriate amount due.

Coupons and Payments

All State employees who are on a Leave of Absence Without Pay will be mailed payment coupons, which must be included with their premium payments at the address shown on the letter included with your premium coupons. Your benefits will be effective as of the date noted on your letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, your coverage will be cancelled. There will be a break in your coverage until you return to work and request re-enrollment in health benefits. This request for re-enrollment must be made through your Agency Benefits Coordinator within 60 days of your return to work.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment worksheet or if you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

Continuation of Coverage (COBRA)

You and/or your dependents may elect to continue your Health, Prescription Drug, Dental, and Health Care Spending Account participation, using post-tax premium payments, for a timeframe determined in accordance with the applicable Federal regulations.

If you or one of your dependents experiences a COBRA qualifying event (as described on the next page), you or your dependent may be eligible to continue the same health benefits that you or your dependents were enrolled under at the time of the COBRA qualifying event.

If coverage is continued under these provisions, you and/or your dependents will be responsible for paying 100% of the premiums, plus an additional 2% of the premium to defray administrative costs. If payment is not received by the end of the grace period, your benefits will be terminated. If your enrollment is cancelled because you did not make the required payment, you will not have the opportunity to enroll again.

Coupons and Payments

All COBRA enrollees will be mailed payment coupons, which must be included with their premium payments at the address on the letter included with your premium coupons. Your COBRA benefits will be effective as of the date noted on your letter, but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the first of every month with a 30-day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the 30-day grace period, your COBRA coverage will be cancelled and you will not be permitted to re-enroll.

COBRA (Continuation of Coverage) Conditions		
QUALIFYING EVENT	**PERSON AFFECTED**	**LENGTH OF CONTINUATION COVERAGE**
Termination of employment (other than for gross misconduct), including layoff or resignation of employee	◆ Employee ◆ Spouse ◆ Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Dependent child(ren) of an employee or retiree no longer meets the dependent eligibility requirements	◆ Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Death of employee or retiree	◆ Spouse ◆ Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Divorce or legal separation from employee or retiree	◆ Former Spouse ◆ Legally Separated Spouse	Indefinitely or until remarriage or until eligible for coverage elsewhere, including Medicare, whichever occurs first COBRA coverage includes the ability to enroll with dependents that meet the eligibility criteria.
	◆ Step-child(ren) of employee or retiree	If enrolled separately, 36 months or until eligible for coverage elsewhere, including Medicare*, whichever occurs first

Qualifying Events After the Start of COBRA (Second Qualifying Events)		
QUALIFYING EVENT	**PERSON AFFECTED**	**LENGTH OF CONTINUATION COVERAGE**
Divorce or legal separation from COBRA participant	◆ Legally Separated Spouse ◆ Step-child(ren) of participant	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Dependent child(ren) of a COBRA participant who no longer meets the dependent eligibility requirements	◆ Child(ren)	36 months from the original qualifying event or until eligible for coverage elsewhere, including Medicare*, whichever occurs first
Total and Permanent Disability of the employee or retiree (as defined by the Social Security Act) within the first 60 days of COBRA coverage	◆ Employee ◆ Spouse ◆ Dependent Child(ren)	The 18 months can be extended to 29 months at increased premiums equal to 150% of usual premiums for the additional 11 months.

* If you are enrolled in Medicare Parts A & B before leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your COBRA coverage after the entitlement date. If you have dependents on your COBRA coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

Payment deadlines are strictly enforced. If you do not receive these coupons within one month of signing your enrollment worksheet or you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division immediately.

The following memorandum entitled General Notice of Continuation of Coverage (COBRA) Rights reviews your COBRA rights and responsibilities. If you have questions about a qualifying event or continuation of coverage, please contact the Employee Benefits Division.

General Notice of Continuation of Coverage (COBRA) Rights

This notice on possible future group health insurance continuation coverage rights applies individually to State employees and all covered dependents. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent whose legal residence is not yours, please provide written notification with the address notification form to the Employee Benefits Division so a notice can be sent to that covered dependent as well. In this notice, the term "employee" also means a retiree.

You are receiving this notice because you have coverage under the State of Maryland Employee and Retiree Health and Welfare Benefits Program (the Program). The Department of Budget and Management Employee Benefits Division administers the Program. The Program sponsored by the State of Maryland is a governmental group health plan covered by the Public Health Service Act, which includes the COBRA continuation of coverage provisions described in this notice. This notice explains continuation coverage rights for only these health benefits offered through the Program: the medical PPO, the medical POS, the medical HMO, the prescription drug plan, the dental PPO, the dental HMO, and the Health Care Spending Account. You may be enrolled in one or more of these benefits. This notice does not apply to any other benefits offered by the State of Maryland or through the Program, such as the dependent day care flexible spending account, life insurance benefit, long term care benefit, or accidental death and dismemberment insurance benefit.

Under Federal law, group health plans like the Program must offer covered employees (including retirees) and covered family members the opportunity for a temporary extension of health coverage (called COBRA continuation coverage) at group rates when coverage under the health plan would otherwise end due to certain qualifying events. This statement is intended to inform all plan participants, in a summary fashion, of potential future options and obligations related to COBRA continuation coverage. Should an actual qualifying event occur in the future, the State of Maryland would send you additional information and the appropriate election notice at that time. Please take special note, however, of your notification obligations that are highlighted later in this statement (see page 44).

Who is Entitled to Elect COBRA Continuation Coverage?

Qualified beneficiaries are entitled to elect COBRA coverage. Qualified beneficiaries are the employee, the spouse, and the dependent children who lost group health coverage as a result of a qualifying event.

What are Qualifying Events and How Will I Know that COBRA Coverage is Available?

When the qualifying event is the end of employment, reduction of employment hours, or death of the employee, the Program will offer COBRA coverage to qualified beneficiaries. You will not need to notify the Employee Benefits Division of these three qualifying events because your employing agency should notify the Employee Benefits Division of those events. You will need to notify the Employee Benefits Division of any other qualifying event.

Qualifying Events for Covered Employee

If you are the covered employee, you may have the right to elect this health plan continuation coverage if you lose your group health coverage because of the following qualifying events: termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment. Remember, the term "covered employee" includes covered retirees in the Program.

Qualifying Events for Covered Spouse

If you are the covered spouse of an employee, you may have the right to elect this health plan continuation coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying events:

- A termination of your spouse's employment (for reasons other than gross misconduct);
- A reduction in your spouse's hours of employment;
- The death of your spouse; or
- Divorce from your spouse. If your spouse (the employee or retiree) reduces or eliminates your group health coverage in anticipation of your divorce or legal separation, and a divorce subsequently occurs, then the divorce may be considered a qualifying event for you even though you lost coverage earlier than the date of the divorce. You must prove that the loss of coverage was in anticipation of the divorce.

Qualifying Events for Covered Dependent Children

If you are the covered dependent child of an employee, you may have the right to elect continuation coverage for yourself if you lose group health coverage under the Program because of any of the following qualifying events:

- A termination of the employee's employment (for reasons other than gross misconduct);
- A reduction in the employee's hours of employment;
- The death of the employee;
- Parent's divorce or, if applicable, legal separation;
- You cease to be a dependent child under the terms of the Program. See eligibility requirements in this booklet.

If you have or adopt a child during your period of COBRA continuation coverage, your child may be eligible for COBRA continuation coverage that runs for the same period as your coverage. The child must meet the eligibility requirements of the Program, and be added within 60 days of the qualifying event (e.g., date of birth, date of adoption/placement, date of loss of other coverage).

When is COBRA Continuation of Coverage Available?

COBRA continuation of coverage starts from the day you lose coverage due to a qualifying event.

- Employees: at the end of the time period covered by your last deduction
- Dependents: the end of the pay cycle in which the qualifying event occurred

Important: Notifications Required from the Employee, Retiree, Spouse, and/or Dependent

For qualifying events when the Program will not provide a notice to you (e.g., divorce or a covered dependent ceasing to meet the definition of a dependent under the Program's rules), you must notify the Employee Benefits Division within 60 days of the date of the qualifying event. If you do not notify the Employee Benefits Division of the qualifying event within 60 days, you will lose the right to elect COBRA coverage. **Under Federal law, this is your responsibility.**

Carefully read the dependent eligibility rules contained in this book so all covered members are familiar with when a dependent ceases to be a dependent under the terms of the plan.

To provide the required notification, you must contact the Employee Benefits Division and request that a COBRA worksheet be mailed to you. You must then fill out the worksheet, attach documentation of the qualifying event (e.g., copy of divorce decree), and mail everything to:

Employee Benefits Division
ATTN: COBRA Unit
301 West Preston Street
Room 510
Baltimore, Maryland 21201

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage; parents may elect COBRA coverage on behalf of minor children who were covered dependents. The Employee Benefits Division will send you an election notice outlining your rights to COBRA continuation coverage after receiving notification of a qualifying event from you or the employee's agency.

Each qualified beneficiary has 60 days from the date of the election notice to return a completed COBRA Enrollment Worksheet. By law, this is the maximum period allowed to elect continuation of coverage

Each qualified beneficiary has the right to elect COBRA continuation of coverage in the group health benefits the qualified beneficiary had on the last day of coverage in the Program. For example, if the qualified beneficiary is enrolled in a medical POS plan and the prescription plan but not a dental plan on the last day of coverage before the qualifying event, the qualified beneficiary may elect to continue coverage in that same medical POS plan and in the prescription plan but may not add coverage under a dental plan during the COBRA election period.

If a qualified beneficiary elects continuation of coverage, the qualified beneficiary will be required to pay the entire cost for the health insurance, plus a 2% administration fee. COBRA continuation of coverage is required to be identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your COBRA coverage as well.

How Long Does COBRA Continuation of Coverage Last?

COBRA coverage is a temporary continuation of coverage. Depending on the nature of the qualifying event that caused the loss of coverage, COBRA coverage may last a maximum of 18 months or 36 months, except in the case of COBRA continuation of coverage in a Health Care Spending Account. If you are participating in a Health Care Spending Account at the time of the qualifying event, you will only be allowed to continue the Health Care Spending Account until the end of the current plan year in which the qualifying event occurs. If you choose to continue your Health Care Spending Account under COBRA, you will pay 102% of the full premium through post-tax payments. See below for a description of how COBRA continuation of coverage may end earlier than these maximum periods.

Length of Continuation Coverage – 18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. This 18-month coverage may be extended in only limited situations: (1) a Social Security disability determination, (2) when a second qualifying event occurs during COBRA continuation of coverage, and (3) when the employee became eligible for Medicare within 18 months before the termination of employment or reduction in hours (see below for explanation). You must notify the Employee Benefits Division in writing within 60 days of either of these events in order to be eligible for an extension of the maximum COBRA coverage period. Failure to do so will jeopardize your ability to have an extension.

Social Security Disability

The 18 months of continuation of coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation of coverage. The disability must last during the entire 18 months of COBRA coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employee Benefits Division within 60 days after the later of: the date of the determination, the date of the termination of employment, the date of the reduction in hours, or the date the original 18-month coverage period begins. This notice must be provided no later than the date the original 18-month coverage period expires. If you do not notify the Employee Benefits Division in writing within the required timeframe, you may lose the ability to extend COBRA coverage.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the premium rate up to the additional 11 months, totaling 29 months. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the 102% level. It is also the qualified beneficiary's responsibility to notify the Employee Benefits Division within 30 days if a final determination has been made that they are no longer disabled.

Secondary Qualifying Events

Another extension of the 18- or above-mentioned 29-month continuation period could occur, if during the 18 or 29 months of COBRA continuation of coverage, a second event takes place (divorce, legal separation, death, or a dependent child ceasing to be a dependent) that would have caused the qualifying beneficiary to lose coverage under the Program if the first qualifying event (termination of employment or reduction of hours) had not occurred. If a second event occurs, then the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Employee Benefits Division in writing within 60 days of the second event and within the original 18- or 29-month continuation period. In no event, however, will continuation of coverage last beyond 36 months from the date of the first qualifying event that originally made the qualified beneficiary eligible for COBRA continuation of coverage. A reduction in hours followed by a termination of employment is not a qualifying second event.

Length of Continuation of Coverage – 36 Months

If the original event causing the loss of coverage was the death of the employee, or a dependent child ceasing to be a dependent child, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event. If the employee became entitled to Medicare benefits less than 18 months before the termination of employment or reduction in work hours, the covered spouse and covered dependent qualifying beneficiaries may be entitled to COBRA coverage for up to 36 months. This extension does not apply to the employee, who will only have a maximum of 18 months of COBRA coverage unless a special extension, as the result of a secondary qualifying event, occurs. The 36-month coverage period cannot be extended.

Length of Continuation of Coverage – Indefinitely

If the original event causing the loss of group health coverage was a divorce from the employee/retiree, Maryland State law gives the qualified beneficiary the opportunity to continue coverage indefinitely, until Program coverage for the employee/retiree terminates, the qualified beneficiary obtains coverage elsewhere (including Medicare), or the qualified beneficiary remarries. This indefinite period of continuation of coverage is a result of a Maryland State law that is similar to COBRA and does not apply to health care flexible spending accounts. However, the dependent child of the qualified beneficiary will also lose coverage when the child does not meet Program eligibility requirements.

Eligibility, Premiums, and Potential Conversion Rights

A qualified beneficiary does not have to show they are insurable to elect continuation of coverage; however, they must have been actually covered by the plan on the day before the event to be eligible for continuation of coverage. An exception to this rule is if while on continuation of coverage a baby is born to or adopted by a covered qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your benefits booklet and must be followed. The plan administrator reserves the right to verify continuation eligibility status and terminate continuation of coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration fee for continuation of coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation of coverage is extended from 18 months to 29 months due to a Social Security disability, the State of Maryland can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums. At the end of the 18, 29, or 36 months of continuation of coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health plan, if an individual conversion plan is available at that time.

Termination of Continuation of Coverage

The timeframes described above are only potential maximum periods for COBRA continuation of coverage. COBRA coverage can end before those periods finish. The law provides that if elected and paid for, your continuation of coverage will end prior to the maximum continuation period for any of the following reasons:

- The State of Maryland ceases to provide any group health plan to any of its employees;
- Any required premium for continuation of coverage is not paid in a timely manner;
- A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
- A qualified beneficiary first becomes entitled to Medicare, after the date of COBRA election;
- A qualified beneficiary extended continuation of coverage up to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- A qualified beneficiary notifies the State of Maryland, Employee Benefits Division they wish to voluntarily cancel continuation of coverage; or
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Is COBRA Continuation of Coverage for My Health Care Spending Account Different?

Yes. COBRA continuation of coverage for the Health Care Spending Account will be offered only to qualified beneficiaries losing coverage through the end of the plan year in which the qualifying event occurs. This coverage cannot be extended beyond the end of the plan year, regardless of the qualifying event or whether a second qualifying event occurs. The use-it-or-lose-it rule will still apply so any unused amounts will be forfeited at the end of the plan year and COBRA coverage will terminate at the end of the plan year. You must pay a premium for continued Health Care Spending Account coverage that includes a 2% administrative fee for the coverage. Unless otherwise elected, all qualified beneficiaries who were covered under the Health Care Spending Account will be covered together for Health Care Spending Account COBRA coverage. However, each qualified beneficiary could elect to exercise Health Care Spending Account COBRA election rights individually to cover the qualified beneficiary only, with a separate Health Care Spending Account limit and a separate premium. Please note that all Health Care FSA premiums are paid with post-tax dollars.

Notification of Address Change

To insure all covered individuals receive information properly and efficiently, you are required to notify the State of Maryland, Employee Benefits Division of any address change as soon as possible. A Change of Address Notification form is available online at www.dbm.maryland.gov, by clicking "Employee Services" and "Health Benefits." Instructions for completing and filing the form are at the bottom of the form and must be followed. Failure on your part to do so will result in delayed notifications or a loss of continuation of coverage options.

How Do I Notify the Employee Benefits Division in Case This Notice Advises I Must Provide Notification to Protect My Rights?

In every instance that you must provide notice to the Employee Benefits Division in order to protect your rights, whether the notice is of a first or second qualifying event, Social Security disability, or the addition of a new qualified beneficiary, you must provide written notice to the Employee Benefits Division at the address below. You may be asked to complete a form and provide additional documentation. Failure to provide a required notice to the Employee Benefits Division within the required time period may cause you to lose COBRA rights.

Any Questions?

Remember, except for notifying you of your responsibilities to notify the Employee Benefits Division of a divorce or a dependent child ceasing to meet Program eligibility requirements, this notice is simply a summary of your potential future options. Should an actual qualifying event occur and it is determined that you are eligible for continuation coverage, you will be notified of all your actual rights at that time as part of the COBRA election notice. If any covered individual does not understand any part of this summary notice or has questions regarding the information or your obligations, please contact the State of Maryland, Employee Benefits Division at 410-767-4775 or 1-800-30-STATE (1-800-307-8283) and press Option 2.

The Program name and address is:

The State of Maryland Employee and Retiree Health and Welfare Benefits Program
c/o Department of Budget and Management Employee Benefits Division
Room 510
301 West Preston Street
Baltimore, Maryland 21201

HIPAA (Health Insurance Portability and Accountability Act)

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A Federal law, HIPAA, requires employers to provide certificates of coverage to all former employees, who then can give the certificates to their new employers. If you or your dependents obtain new employment, you may request a certificate of coverage from the State, which describes the length and types of benefits coverage (e.g., medical, dental, etc.) you and your dependents had under the State Program. You may request a HIPAA Certificate of Coverage by writing to the Department of Budget and Management (DBM), Employee Benefits Division, at the address on the inside front cover of this book. The medical plans offered through the State will mail one to you automatically when your coverage with them ends.

Notice of Privacy Practices and HIPAA Authorization Form

The State conforms to the Federal HIPAA regulations and State regulations on the privacy of your health information. Please read the Notice of Privacy Practices below, which describes the privacy practices of the State Employees Health Benefits Program.

HIPAA and State regulations require your written authorization to disclose certain health information to other people. If your written authorization is needed, you may use the HIPAA authorization form to provide the needed authorization that is located on our website, www.dbm.maryland.gov. Assigned HIPAA authorization remains in effect, unless you change or revoke the authorization.

Notice of Privacy Practices – State Employee and Retiree Health Benefits Program

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Under Federal and State law, DBM administers the State Employee and Retiree Health Benefits Program (the Program) and protects the privacy of your protected health information. DBM takes steps to ensure that your protected health information is kept secure and confidential and is used only when necessary to administer the Program. DBM is required to give you this notice to tell you how DBM may use and give out ("disclose") your protected health information held by DBM. This information generally comes to DBM from you when you enroll in a health plan and from your health plan in the administration of the Program.

Your health plan in the Program (for example, the CareFirst BlueCross BlueShield PPO or the Optimum Choice HMO) will also protect, use, and disclose your personal health information. For questions about your health information held by your health plan, please contact your health plan directly. The plans in the Program all follow the same general rules that DBM follows to protect, use, and disclose your protected health information. Each plan will use and disclose your protected health information for payment purposes, for treatment purposes, and for administration purposes.

DBM has the right to use and disclose your protected health information to administer the Program. For example, DBM will use and disclose your protected health information:

- To communicate with your Program health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue. DBM may need a written authorization from you for your health plan to discuss your case.
- To determine your eligibility for benefits and to administer your enrollment in your chosen health plan.
- For payment related purposes, such as to pay claims for services provided to you by doctors, hospitals, pharmacies, and others for services delivered to you that are covered by your health plan, to coordinate your benefits with other benefit plans (including Workers' Compensation plans or Medicare), or to make premium payments.
- To collect payment from you when necessary, such as co-payments or premiums.
- For treatment related purposes, such as to review, make a decision about, or litigate any disputed or denied claims.
- For health care operations, such as to conduct audits of your health plan's quality and claims payments and to procure health benefits offered through this Program.

DBM will also use and disclose your protected health information:

- To you or someone who has the legal right to act for you (your personal representative). To authorize someone other than you to discuss your protected health information with DBM, please contact DBM to complete an authorization form.
- To law enforcement officials when investigating and/or processing alleged or ongoing civil or criminal actions.
- Where required by law, such as to the Secretary of the U.S Department of Health and Human Services, to the Office of Legislative Audits, or in response to a subpoena.
- For health care oversight activities (such as mandatory reporting, and fraud and abuse investigations).
- To avoid a serious and imminent threat to health or safety.

DBM must have written permission (an "authorization") from you, or your dependents over the age of 18 years, to use or give out your protected health information to other persons or organizations as already described in the notice. By law, you have the right to:

- Make a written request and see or get a copy of your protected health information held by DBM or a plan in the Program.
- Amend any of your protected health information created by DBM if you believe that it is wrong or if information is missing, and DBM agrees. If DBM disagrees, you may have a statement of your disagreement added to your protected health information.
- Ask DBM in writing for a listing of those getting your protected health information from DBM for up to six years prior to your request. The listing will not cover your protected health information that was used or disclosed for treatment, health care operations or payment purposes, given to you or your personal representative, disclosed pursuant to an authorization, or disclosed prior to April 14, 2003.
- Ask DBM in writing to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address) if using your address on file creates a danger to you.
- Ask DBM in writing to limit how your protected health information is used or given out. However, DBM may not be able to agree to your request if the information is used for treatment, payment, or to conduct operations in the manner described above, or if a disclosure is required by law.
- Get a separate paper copy of this notice.

If you wish to exercise any of these rights in connection with the Program or a health plan in the Program, you may contact DBM at the address below. You may also contact your dental plan, medical PPO, medical POS, or medical HMO plan directly.

For more information on exercising your rights set out in this notice, visit the DBM website: www.dbm.maryland.gov. You may also call 410-767-4775 or 1-800-30-STATE (1-800-307-8283) and ask for DBM's Program privacy official for this purpose. If you believe DBM has violated your privacy rights set out in this notice, you may file a written complaint with DBM at the following address:

Department of Budget and Management
Employee Benefits Division
301 West Preston Street
Room 510
Baltimore, MD 21201
ATTN: HIPAA Privacy Officer

Filing a complaint will not affect your benefits under the Program. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Department of Health and Human Services
Office of Civil Rights
150 South Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111

Medicare Coordination of Benefits (COB)

Medicare Parts A & B

Active employees and their covered dependents do not have to sign up for Medicare when they become eligible because of age or disability, but instead, keep using the State health benefits as their only coverage. However, retirees and dependents of retirees must enroll in both Medicare Parts A & B as soon as they are eligible (due to age or disability) to have full claims coverage. If you are a retiree or a covered dependent of a retiree and you are eligible for Medicare, Parts A & B become your primary insurance and the State health plan becomes a supplemental policy to Medicare. Medicare Part A helps pay for hospital care, some skilled nursing facility care, and hospice care; Medicare Part B helps pay for physician charges and other medical services.

If you are an employee, retiree, or a covered dependent that has Medicare entitlement because of End Stage Renal Disease (ESRD), see the ESRD rules on this page.

Retirees and/or their dependents enrolled in the State Health Benefits Program must enroll in both Parts A & B as soon as they are eligible, either due to age or disability. The State plan will cover only that portion of hospital and medical bills not covered by Medicare. If you and/or your covered dependents are eligible for, but not enrolled in both Parts A & B, you will become responsible for the claims costs that Medicare would have paid.

Age

For most individuals who are not disabled, Medicare eligibility begins on the first day of the month in which they reach age 65. However, if you were born on the first day of a month, your Medicare eligibility begins on the first day of the month prior to the month in which you reach age 65. In order to have full coverage, retirees and their covered dependents must enroll in Parts A & B at age 65, regardless of what the Social Security Administration determines to be your full retirement age.

Disability

Persons who are certified as being disabled by the Social Security Administration become eligible for Medicare two years (24 months) after their disability determination date. In order to have full coverage, retirees and their covered dependents must enroll in Parts A & B if eligible due to disability, regardless of their age. If Social Security denies Medicare coverage, you must provide a copy of the Social Security's denial to the Employee Benefits Division. If your Medicare entitlement is due to disability and the Social Security Administration determines that your disability status ends, please provide the Employee Benefits Division documentation from the Social Security Administration stating when Medicare entitlement ended.

End Stage Renal Disease (ESRD)

If a retiree or covered dependent's Medicare eligibility is due to ESRD, they must sign up for both Medicare Parts A & B as soon as they are eligible. If an active employee or covered dependent's Medicare eligibility is due to ESRD, they should sign up for both Medicare Parts A & B as soon as they are eligible. The Social Security Administration has determined that individuals who have permanent kidney failure (ESRD), regardless of their age, can receive services through Medicare. If you or your covered dependents are entitled to Medicare due to ESRD, contact your local Social Security Office to request the handbook, Medicare Coverage of Kidney Dialysis and Kidney Transplant Service. Your coverage level in your State health plan should not be changed to a Medicare coverage level until the end of the 30-month Coordination of Benefits (COB) period.

The Centers for Medicare and Medicaid Services (CMS) has determined that when Medicare is due to ESRD, whether you are an active employee or a retiree, your State health plan will remain your primary insurer for the first 30 months. At the end of the 30-month COB period, Medicare becomes the primary insurer. Before your 30-month COB period ends, you should contact the Employee Benefits Division to complete an enrollment form, changing your State health plan to a Medicare supplemental policy.

If you are no longer eligible for Medicare Parts A & B for ESRD, please contact your local Social Security Office and request a cancellation of both Medicare Parts A & B. When you receive your cancellation letter from the Social Security Administration, please complete an Enrollment Worksheet to change your coverage level and submit it to the Employee Benefits Division at the address on the inside front cover of this booklet with a copy of the notice of cancellation of your Medicare coverage.

Questions About Medicare COB

If you have questions about your coverage level in the State Retiree Health Benefits Program, or if you have questions about claims payments and how your plan coordinates with Medicare, contact the Employee Benefits Division at the phone number on the inside front cover of this booklet.

Medicare Part D – New Medicare Drug Benefit

How Does This Apply to You?

If you have prescription drug coverage through the State Employee and Retiree Health Benefits Program, you are not required to enroll in Medicare Part D. For most people, keeping the State coverage and not enrolling in a Medicare Part D plan will be the most cost-effective prescription drug coverage. However, you should consider the premium, co-pay, coinsurance, deductible, and coverage gap costs under the plans you are considering to make the best decision for your personal coverage. For the 2006-2007 plan year, the State of Maryland Prescription Drug Plan continues to be as good as, or better than, the standard Medicare Part D plan. See the Notice of Creditable Coverage on pages 50 through 51 of this booklet.

If you have State prescription drug coverage, the Notice of Creditable coverage means that if you decide to keep the State prescription drug coverage and not enroll in Medicare Part D, you will be permitted to enroll in Medicare Part D at a later time without paying a higher premium, as long as you do not have a break in coverage of 63 or more days.

Retirees and Their Covered Dependents

If you decide to buy the Medicare Part D coverage and keep your State prescription coverage, Medicare Part D will become your primary source of prescription drug coverage, and the State coverage will be secondary. In other words, Medicare will pay benefits first, and then the State coverage will coordinate with the benefits that Medicare pays. Remember, you will have to pay both monthly premiums.

Here's How the State Plan Will Work as Your Secondary Coverage When You Have Primary Coverage Through Medicare Part D

- You will give the pharmacist your Medicare Part D card first as your primary insurance and your State prescription card as your secondary insurance.
- You must meet an annual Medicare Part D deductible before Medicare will begin to pay benefits. During this time, your State coverage will pay benefits and you will only be required to pay the applicable co-pays for State coverage. Once your co-pays combined with the State payments reach the annual Medicare deductible, Medicare will begin paying benefits. Your true out-of-pocket (TROOP) cost for the Part D plan will only reflect what you paid, and not what the State paid.
- After you have met any Medicare annual deductible, Medicare Part D will pay their portion of eligible costs of the drugs on their preferred drug list, up to the determined coverage gap. The State will pay benefits and will make up the difference between what Medicare pays, if anything, and the applicable State co-pay you are required to pay.
- When the amount of State co-pays you have paid during the fiscal year reaches $700, you will have met the out-of-pocket maximum for the State prescription drug coverage. This means the State plan pays for eligible expenses not covered by your Medicare Part D plan in full for the rest of the plan year. You should still give your pharmacist your Medicare Part D card.

Active Employees and Covered Dependents

If you have prescription drug coverage because you are still working, or because your spouse or family member is still working, the employer coverage will remain your primary prescription drug coverage unless you drop it. If that coverage is creditable coverage, you can wait to enroll in Medicare Part D until a later time, and you will not pay more for your Part D premium when you enroll, as long as you do not have a break in coverage of 63 or more days.

Benefits Appeal Process

The Department of Budget and Management strives to ensure proper coverage and claims payments under the benefits Program. If you believe that your plan has denied payment of a covered benefit to which you are entitled, you should contact the plan first. The plan will explain its internal appeal process and inform you of the steps you must take to file an appeal to the plan. HMO members may also file an appeal to the Maryland Insurance Administration (MIA).

Once you have exhausted all of the plan's appeal processes, if you are not satisfied with the plan's decision following its review of your appeal, you may submit a written request for review by the State Benefits Review Committee of the Department of Budget and Management. The State Benefits Review Committee reviews appeals by members and providers on denied benefits and/or disputed claims payments. This request must be submitted in writing within 30 days of your receipt of the plan's decision.

For Dispute of Claims Payments

You should describe the nature of your claim and the reasons why you believe that the claim has been improperly denied, along with any supporting documentation, which may include a HIPAA Authorization Release Form. This form can be found on our website: www.dbm.maryland.gov by clicking Employee Services, then Health Benefits.

For Prescription Drug Appeals

You must submit the following:

- A cover letter from you;
- Letter from your treating physician with detailed medical justification for your appeal; and
- Denial letter from the Plan.

The address of the Benefits Review Committee is:

Benefits Review Committee
Department of Budget and Management
301 West Preston Street, Room 510
Baltimore, Maryland, 21201

Or you can fax your appeal to 410-333-7122.

Robert L. Ehrlich, Jr.
Governor

Michael S. Steele
Lt. Governor

Cecilia Januszkiewicz

John Wasilisin
Deputy Secretary

Important Notice From the State of Maryland About Prescription Drug Coverage and Medicare

NOTICE OF CREDITABLE COVERAGE

Please read this notice carefully and keep it where you can find it. This notice applies to all State of Maryland employees, retirees, and dependents who are entitled to Medicare and are enrolled in the current prescription drug plan through the State Employee and Retiree Health Benefits Program ("our Program") and has information about our Program's prescription drug coverage. It also explains the options you have under Medicare Part D prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Important Points to Remember

- Medicare prescription drug coverage ("Medicare Part D") became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- The State of Maryland has determined that the prescription drug coverage offered through our Program is **creditable coverage**. **Creditable coverage** means that, on average for all plan participants, our Program is expected to pay out as much or more than the standard Medicare Part D prescription drug coverage will pay. It also means that **if you keep our Program's coverage and do not enroll in a Medicare prescription plan now, you will not pay extra if you later decide to enroll in a Medicare prescription drug plan, so long as you do not have a break in coverage of 63 days or more.**

  If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.
- Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. In addition, if you cancel or lose coverage with our Program, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

  You should compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare prescription drug plans in your area. Remember, our Program will only cover eligible dependents in a plan in which you are enrolled as well.

If you are eligible for Medicare prescription drug coverage, you have the right to:

- Keep our Program's coverage and not enroll in a Medicare prescription drug plan;
- Enroll in a Medicare prescription drug plan and drop our Program's coverage; or
- Enroll in a Medicare prescription drug plan and keep our Program's coverage.*

* If your coverage in our Program is as a retiree or a covered dependent of a retiree, your Medicare prescription drug plan will be your primary coverage.

- **If you decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage through our Program, you may not be able to get our Program coverage back until our next Open Enrollment period or when you cancel or lose your Medicare prescription drug coverage.** If you lose or cancel Medicare Part D prescription drug coverage, you may be able to re-enroll in our Program before the next annual Open Enrollment period **if** you request re-enrollment with the Employee Benefits Division within 60 days **and** you have had a change in circumstances that permits a mid-year change in enrollment. See the annual Benefits Booklet section entitled "Enrollment and Changes Outside of Open Enrollment" (see page 12) for more information. If you drop our Program coverage for prescription drug benefits, your dependent(s) will also lose coverage under our Program's prescription drug plan.
- **Keep this notice with your important papers.** If you enroll in one of the Part D plans approved by Medicare that offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

For more information about this notice or your current prescription drug coverage:

Contact the Employee Benefits Division for further information at 410-767-4775 or 1-800-307-8283. More information can also be found by going to our website, www.dbm.maryland.gov and clicking "Employee Services" and "Health Benefits." Please note: A copy of this Notice will appear in our Program's annual Open Enrollment booklet each year. You also may request a paper copy at any time.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. If you are enrolled in Medicare, you will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook or visit www.mdoa.state.md.us/ship.html for the telephone number of the local office in your area); and
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember:

Keep this notice. If you enroll in one of the prescription drug plans approved by Medicare, you may be required to provide a copy of this notice when you join to determine whether or not you are required to pay a higher premium amount.

Date:	07/01/06
Name of Entity/Sender:	State of Maryland
Contact Office:	Employee Benefits Division
Address:	301 W. Preston Street, Room 510 Baltimore, Maryland 21201
Phone Number:	410-767-4775 or toll-free 1-800-307-8283

July 2006 – June 2007 Premium Rates for Term Life Insurance

Age of Employee/ Retiree	Bi-Weekly Employee/ Retiree Rate (per $10,000)	Monthly Employee/ Retiree Rate (per $10,000)	Age of Spouse	Bi-Weekly Spouse Rate (per $5,000)	Monthly Spouse Rate (per $5,000)
Under 20	$0.29	$0.58	Under 20	$0.31	$0.62
20 to 29	$0.29	$0.58	20 to 29	$0.31	$0.62
30 to 34	$0.35	$0.70	30 to 34	$0.34	$0.68
35 to 39	$0.46	$0.92	35 to 39	$0.42	$0.84
40 to 44	$0.72	$1.43	40 to 44	$0.62	$1.24
45 to 49	$1.16	$2.32	45 to 49	$0.96	$1.92
50 to 54	$1.88	$3.75	50 to 54	$1.44	$2.87
55 to 59	$3.24	$6.48	55 to 59	$2.23	$4.45
60 to 64	$4.68	$9.36	60 to 64	$3.41	$6.82
65 to 69	$6.99	$13.98	65 to 69	$4.96	$9.92
70 to 74	$12.51	$25.02	70 to 74	$7.80	$15.60
75 to 79	$24.47	$48.94	75 to 79	$7.80	$15.60
80 and older	$24.47	$48.94	80 and older	$7.80	$15.60
Dependent Child Coverage is $0.95 per $5,000 per month					

July 2006 – June 2007 Premium Rates for AD&D Insurance

Plan Coverage Level	Employee Only Bi-Weekly	Employee + Family Bi-Weekly	Employee Only Monthly	Employee + Family Monthly
$100,000	$0.90	$1.65	$1.80	$3.30
$200,000	$1.80	$3.30	$3.60	$6.60
$300,000	$2.70	$4.95	$5.40	$9.90

July 2006 – June 2007 Employee Premium Rates for Medical Coverage

	Bi-Weekly Medical Premiums			Monthly Medical Premiums		
	1 PERSON	2 PEOPLE	3+ PEOPLE	1 PERSON	2 PEOPLE	3+ PEOPLE
CareFirst BlueCross BlueShield PPO	$41.34	$74.42	$103.36	$82.68	$148.83	$206.71
MLH-Eagle PPO	$38.50	$69.30	$96.26	$77.00	$138.60	$192.52
Aetna Quality POS	$26.94	$48.50	$67.35	$53.88	$97.00	$134.70
CareFirst BlueCross BlueShield Maryland POS	$26.63	$47.93	$66.57	$53.25	$95.85	$133.13
M.D.IPA Preferred POS	$27.28	$49.10	$68.19	$54.55	$98.19	$136.38
CareFirst BlueCross BlueShield BlueChoice HMO	$24.53	$51.47	$63.77	$49.05	$102.94	$127.53
Kaiser Permanente HMO	$23.32	$46.64	$58.41	$46.64	$93.28	$116.82
Optimum Choice HMO	$22.98	$47.78	$56.97	$45.95	$95.56	$113.93

Note for all retired employees and their dependents with Medicare:
See next page for medical plan premium rates with Medicare.

July 2006 – June 2007 Premium Rates for Prescription Drug Coverage

Prescription Plan Coverage Level	Bi-Weekly Prescription Premiums	Monthly Prescription Premiums
Employee Only	$17.15	$34.30
Employee & One Child	$22.80	$45.59
Employee & Spouse	$28.46	$56.93
Employee & 2 or More	$34.30	$68.61

July 2006 – June 2007 Premium Rates for Dental Coverage

Dental Plan Coverage Level	Bi-Weekly Dental Premiums			Monthly Dental Premiums		
	DENTAL BENEFIT PROVIDERS DHMO	UNITED CONCORDIA DHMO	UNITED CONCORDIA DPPO	DENTAL BENEFIT PROVIDERS DHMO	UNITED CONCORDIA DHMO	UNITED CONCORDIA DPPO
Employee Only	$3.44	$3.59	$5.71	$6.88	$7.18	$11.43
Employee & One Child	$6.88	$6.26	$10.92	$13.76	$12.51	$21.84
Employee & Spouse	$7.57	$7.19	$11.43	$15.14	$14.38	$22.85
Employee & 2 or More	$12.04	$10.10	$21.41	$24.08	$20.21	$42.81

July 2006 – June 2007 Retiree Premium Rates for Medical Coverage

Monthly Medical Premiums without Medicare					Monthly Medical Premiums with Medicare						
MEDICAL PLANS	RETIREE ONLY	RETIREE & CHILD	RETIREE & SPOUSE	RETIREE & 2 OR MORE	RETIREE ONLY WITH MEDICARE	RETIREE + 1, 1 WITH MEDICARE	RETIREE + 1, BOTH WITH MEDICARE	RETIREE + 2, 1 WITH MEDICARE	RETIREE + 2, 2 WITH MEDICARE	RETIREE + 2 OR MORE, ALL WITH MEDICARE	RETIREE + 3 OR MORE; 1, 2, OR 3 WITH MEDICARE
CareFirst BlueCross BlueShield PPO	$82.68	$148.83	$148.83	$206.71	$41.35	$124.01	$82.68	$190.16	$165.36	$124.01	$206.71
MLH-Eagle PPO	$77.00	$138.60	$138.60	$192.52	$38.50	$115.49	$77.00	$177.09	$154.00	$115.49	$192.52
Aetna Quality QPOS	$53.88	$97.00	$97.00	$134.70	$26.93	$80.81	$53.88	$123.92	$107.76	$80.81	$134.70
CareFirst BlueCross BlueShield POS	$53.25	$95.85	$95.85	$133.13	$26.62	$79.88	$53.25	$122.48	$106.50	$79.88	$133.13
M.D.IPA Preferred POS	$54.55	$98.19	$98.19	$136.38	$27.27	$81.82	$54.55	$125.46	$109.10	$81.82	$136.38
CareFirst BlueCross BlueShield BlueChoice HMO	$49.05	$102.94	$102.94	$127.53	$24.18	$72.83	$53.13	$121.49	$77.49	$66.46	$120.92
Kaiser Permanente HMO	$46.64	$93.28	$93.28	$116.82	$27.65	$74.29	$55.31	$116.82	$101.95	$82.96	$116.82
Optimum Choice HMO	$45.95	$95.56	$95.56	$113.93	$30.34	$76.28	$60.68	$113.93	$104.17	$91.02	$113.93

These rates are based on 16 years of Creditable State service. The amount the State subsidizes varies by years of creditable service. Therefore, the amount of money deducted from your retirement check may be more than what is shown on this page. The premiums for Retirees of the Optional Retirement Program (ORP) may also vary from these rates.

To enroll, call the Interactive Voice Response (IVR) system at:

410-669-3893 or 1-888-578-6434
TTY/TDD 410-333-5244

during open enrollment
24 hours a day, 7 days a week.